



The New Zealand
Psychological Society

Te Rōpū Mātai Hinengaro o Aotearoa

Psychology Aotearoa



NZPsS Submission on Child Poverty - 65
Tumeke Bro'...reflections of a white male counsellor - 79
Indigenous Australian Mental Health and Racism - 85

Change in Dialectical Behaviour Therapy - 92
Sociolinguistics and language in the workplace - 120
Resilience in New Zealand psychologists - 132

Kia ora and welcome to *Psychology Aotearoa* the official twice yearly publication of the New Zealand Psychological Society. *Psychology Aotearoa* aims to inform members about current practice issues, discuss social and political issues of importance to psychologists, celebrate the achievements of members, provide a forum for bicultural issues and highlight research and new ideas relevant to psychology. It also aims to encourage contributions from students, hear the views of members and connect members with their peers.

Being part of *Psychology Aotearoa*

We welcome your contributions to *Psychology Aotearoa*. We are looking for submissions related to psychology which readers will find stimulating and can engage with. This can include items on practice and education issues, social and political issues impacting on psychology, bicultural issues, research in psychology, historical perspectives, theoretical and philosophical issues, kaupapa Māori and Pasifika psychology, book reviews, ethical issues and student issues.

For more information on making submissions to "*Psychology Aotearoa*" – go to www.psychology.org.nz/Psychology_Aotearoa

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The New Zealand Psychological Society

Te Rōpū Mātai Hinengaro o Aotearoa

The New Zealand Psychological Society is the premier professional association for psychologists in Aotearoa New Zealand. Established as a stand-alone incorporated society in 1947, it now has over 1000 members and subscribers. The Society provides representation, services and support for its New Zealand and overseas members.

Psychology Aotearoa is the Society's member-only periodical published twice a year. It contains articles and feature sections on topics of general interest to psychologists including the teaching, training and practice of psychology in Aotearoa New Zealand, research and new developments in psychology, application of psychology to current and social and political issues.

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Printed by Metroprint

ISSN 1179-3961 (Print)

ISSN 1179-397X (Online)

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Contents



President's Korero	62
President Peter Coleman makes connections between economic and political decisions and health and wellbeing in society	

Editorial	63
Mike O'Driscoll previews the rich diversity of this issue: something of interest for everyone	

NZPsS News

NZPsS AGM	65
NZPsS Submission on Child Poverty	65

Psych-News

Reports on psychology issues from a range of publications	70
---	----

A Point of view

<i>The way of the dodo</i> - Alison Kirby gives her view of the state of educational psychology in New Zealand	72
---	----

Forum

<i>Refugee policy issues in New Zealand</i> - Gary Poole and Arif Saeid reflect on involuntary detention of asylum claimants	74
--	----

Bicultural Issues

<i>Tumeke Bro?</i> - Nick Mulqueeny reflects on his work with male Māori tamariki	79
--	----

Practice- Research-Education

<i>Indigenous Australian Mental Health and Racism</i> - Pat Dudgeon critically examines the role of psychology in colonisation in Australia	85
<i>Processes of change in dialectical behaviour therapy</i> are discussed by Alan Fruzzetti	92
<i>Tōku reo, tōku ngākau: Learning the Language of the Heart</i> - Erana Cooper explores working with Māori as colleagues and advocates for social justice	97
<i>How best to support someone quitting smoking</i> - Karen Evison from the Ministry of Health speaks with psychologist Veronika Isler	104
<i>Researching the success of Māori achievers</i> - Angus Macfarlane outlines research which is looking at what motivates successful Māori learners	106
<i>The Psychologists Board accreditation process</i> - Anne Goodhead outlines the Board's process for accrediting psychology training programmes	108
<i>Abstracts of students' theses</i> - clinical psychology Masters and PhD theses abstracts from a number of universities	110

Interdisciplinary Perspectives

Janet Holmes from Victoria University talks about sociolinguistics and language in the workplace	120
---	-----

One on one

Erana Cooper reflects... ..	122
------------------------------------	-----

Reviews

Jackie Feather reviews John Briere and Cheryl Lanktree's book on <i>Treating complex trauma in adolescents and young children</i>	124
--	-----

See over for more contents





Student Forum

- Editorial - Rosalind Case* congratulates student conference presenter prize winners for the excellent student contributions in this section 125
- The association between Vitamin D status and depression in a non-clinical sample* is presented in poster form by **Maria Polak** 127
- Client change in Waikeria Prison's Māori Focus Unit* is explored by **Tess Chalmers** 128
- Resilience in New Zealand psychologists* is discussed by **Katie McCormick** 132
- The qualitative assessment of the cognitive outcomes of electroconvulsive therapy* is discussed by **Kiri Luther** 135
- Current research into the etiology of inflated responsibility and thought-action fusion in psychopathology* is discussed by **Kirsty Fraser** 138
- Glen Kilgour** provides an outline of the *supervision for registration scheme* pathway 142

President's Korero—Peter Coleman



The social sciences are often regarded as poor cousins to the physical, biological and medical sciences, despite - certainly in psychology - having a robust research methodology and well-documented interventions and outcomes. The development of psychology as a science has only been possible because of the

parallel development of this research methodology. This was well articulated by Professor David Barlow (Boston University) who demonstrated the increasing efficacy of psychological interventions, most often behavioural in origin at the 2012 NZPsS and NZCCP joint conference in Wellington. His seminal book "Single Case Experimental Designs" co-written with Michael Hersen (1976, 2nd Edn. 1984, 3rd Edn. with Matthew Nock 2008) was for this aging practitioner both a primer and a bible. Psychology could certainly teach the medical sciences with their high reliance on population-level co-relational studies and randomised control treatment (RCT) designs a thing or two, including about individuality and causality.

Within the social sciences economics is viewed as a 'hard' science whilst psychology - which originated from introspective philosophy - is often viewed as 'soft' science. However in the past decade or so economics and the related sub-disciplines within the banking and financial industries have to say the least had a crisis of their own. One doesn't have to be too avid a reader to notice that they have

spectacularly failed to predict, explain and manage each of the economic crises that have played out in recent years. Can we take some comfort from this? Strangely enough the answer is probably an emphatic "yes".

George Soros, who nearly broke the Bank of England in the 1980s by 'betting' against Sterling, presented a thoughtful speech at the "Festival of Economics" in Trento Italy earlier this year (retrieved from <http://www.Ecomonitor.com>). He argued that in the physical sciences objective 'facts' serve to validate theories which can then be used to predict outcomes. However in economics 'facts' are presented by the very people whose decisions influence the eventual outcomes, an unassailable scientific contradiction he suggests. Soros also likens the current European financial crisis to other speculative bubbles, for example the banking crisis of 1982, the stock market collapse of 1987, the burst of the IT bubble in early 2000, of the housing market in the USA and elsewhere in 2008 and dare I predict, Facebook and eventually Apple. His message is that all of these collapses reflected a crisis of confidence in what was initially regarded as a "fantastic object" or idea, rather than a collapse of fundamental and rational economic values, hastened perhaps by unenlightened political decisions. It is inevitably the economically weaker countries and citizens who are burdened by the eventual cost of these collapses.

Why should this interest us? Simply because there is a direct link between poverty and virtually every negative social indicator that we care to measure, mediated by

unemployment, housing, education and health issues. We as psychologists are committed to the ideals of social equity and have contributed to the reduction of discrimination and social barriers on the basis of race, ethnic or national origin, traditions, age, gender, sexual preference, marital status, religious belief, disability etc. These ideals which were sometimes bitterly fought for and against are now enshrined in our laws (e.g. Treaty of Waitangi Act, 1975; Human Rights Act, 1993; Crimes (Substituted Section 59) Amendment Act, 2007). There is one 'right' which still eludes us, and that is a more equal distribution of wealth and opportunity. A key resource in this debate is the recent book "The Spirit Level" (Wilkinson and Pickett, 2009) which demonstrates the causal link between social inequality and individual health and wellbeing.

The NZ Psychological Society has been very active in making submissions to Parliamentary enquiries and Governmental Ministry reviews on just these issues. (Note to self: if I haven't read these on the NZ Psychological Society website (www.psychology.org.nz/Submissions), I will make it a priority to do so). We probably shouldn't be too surprised that the more affluent sections of society and their political representatives are vehemently opposed to these arguments. Perhaps they should reconsider Alexis de Tocqueville's 1835 tract about 'enlightened self-interest'. After all, some have long recognised that there has to be a market for their products and that this won't occur if there is high unemployment. For example Henry Ford's genius was as much on providing a liveable hourly working rate for his employees so that they could buy his 'Model T' rather than as commonly thought the development of mechanised production lines. It is ironic that Soros a hard-nosed financial speculator has in 2012 redrawn our attention to the key place that hope, expectation and a liveable income plays in keeping the factories running and national economies healthy. We have to ensure that the Governments of the day listen to this message and also implement practical solutions to child poverty (The Office of the Children's Commissioner, 2012), and do it very soon.

Hersen M and Barlow D H (1976), *Single Case Experimental Design: Strategies for Studying Behaviour Change*, Pergamon Press

The Office of the Children's Commissioner (2012), *Report on Solutions to Child Poverty in New Zealand*, The Office of the Children's Commissioner

Tocqueville A (1835), *Democracy in America*

Wilkinson, R. G., & Pickett, K. (2009), *The Spirit Level: Why More Equal Societies Almost Always Do Better*. London: Allen Lane

Editorial



Tēnā koutou colleagues,

This is the second issue of *Psychology Aotearoa* for 2012, and like previous issues it features a very diverse range of topics, issues and papers, including the findings from a survey of members conducted by the Society, which

provides interesting information on members' views and perceptions of our profession.

I would like to begin by thanking Frank O'Connor for his valiant service as president of NZPpS over the past two years, which have been a time of considerable activity and have reinforced the need to continue to promote the role of psychology in society. Frank has performed admirably in the presidential role, and I am sure that we all appreciate his significant contributions. We now welcome our new president, Peter Coleman, and his new team of directors and assistants, and wish them well over the next two-year period.

In this issue, there are several features which are of great interest. There are 'think-piece' articles by Alison Kirby (on the role of educational psychologists), Nick Mulqueeney (on being a pakeha counsellor with Māori clients), and Gary Poole and Arif Saeid (on the detention of refugees). These papers raise challenging issues for consideration. Angus MacFarlane discusses the critical issue of researching the success of Māori achievers, which has received much less attention than it warrants. There are also two research based papers, one by Katie McCormick of Auckland University (on the resilience of psychologists!) and the second by Kiri Luther of Massey University (on the experiences of ECT patients). Both of these contain interesting and thought-provoking information. I would like to thank all these authors for their contributions to the present issue of *Psychology Aotearoa*.

Also of considerable interest will be the paper by Anne Goodhead from the Psychologists Board, reporting on the accreditation process. At a time when the positioning of psychology under the Health Practitioners Competency Assurance Act is being reviewed and discussed, Anne's summary offers some very valuable insights into the important process of programme accreditation.

Another feature in this issue is the inclusion of Masters and PhD thesis abstracts. We began including thesis abstracts a couple of years ago, although we have not been able to incorporate these in every issue of *Psychology*

Aotearoa. This time we present abstracts of theses in the area of clinical psychology, from Massey, Otago, Victoria and Waikato universities. We believe this information is valuable to circulate to members to increase awareness of the types of research being conducted by students. Another example of student research is presented by Tess Chalmers, winner of the 2011 Karahipi Tumuaki President's Scholarship; her paper is included here also.

Finally, I would like to thank all those who have contributed items to this issue of *Psychology Aotearoa* and I encourage you to continue sending your contributions. In addition, if you have any feedback on the content or the format of the *Psychology Aotearoa*, please do not hesitate to contact us. Special thanks to co-editor Pam Hyde and her team for compiling this issue of *Psychology Aotearoa*. Your tireless efforts have made it possible!

Ngā mihi nui,

Michael O'Driscoll

Co-Editor (m.odriscoll@waikato.ac.nz)



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Te Rōpū Mātai Hinengaro o Aotearoa

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The reconvened AGM took place on 23 August at the NZPsS National Office. This meeting was a continuation of the AGM on 22 April at the Joint NZPsS/NZCCP conference in Wellington. (The powerpoint presentation on NZPsS activities/achievements presented by President, Frank O'Connor and Executive Director, Pamela Hyde at the April meeting can be accessed on the "members' only" section of the website). The financial report was received as was an updated membership report at the August meeting. There was a discussion on the need to celebrate the achievements of NZPsS members by appointing more Fellows. A motion was passed to this effect.

Nominations of members to the Executive were received and accepted. Members of the Executive are

Peter Coleman- President

Dr Kerry Gibson-President-Elect

Dr Erana Cooper- Director of Bicultural Issues

Dr Waikaremoana Waitoki- Director of Bicultural Issues

Joanne Cunningham- Director of Professional Issues-

Dr Jackie Feather -Director of Scientific Affairs-

Iris Fontanilla- Director of Professional Development and Training

Quentin Abraham -Director of Social Issues

Kaihautū- Professor Angus Macfarlane

For more information about members of the Executive see the September edition of Connections or go to <http://www.psychology.org.nz/Executive>

The following remit was considered: "That the New Zealand Psychological Society create a new category of membership entitled "Retired Member" to encourage those members who are no longer in paid employment to maintain their contact and involvement in the Society". This issue was discussed in relation to retired members who may wish to continue their membership of the NZPsS but are finding that a reduced income makes this difficult. It was noted that there is already a reduced fee rate for members who are having difficulties affording the membership fee. The remit was amended to allow the Society to "explore creating" a retired membership category.

New President Peter Coleman, thanked Frank O'Connor

and Dr Rose Black for their much appreciated hard work on behalf of the Society. Frank and Rose were each presented with a gift on behalf of the Society and Frank's work was also acknowledged by Moana Waitoki on behalf of NSCBI (National Standing Committee on Bicultural Issues).

The meeting was closed by Kaihautū Angus Macfarlane with a karakia.

The following submission was made by the NZPsS to the Office of the Children's Commissioner on the "Report on Solutions to Child Poverty in New Zealand".

The New Zealand Psychological Society welcomes the opportunity to comment on the Solutions to Child Poverty in New Zealand proposed by the Children's Commissioner's Expert Advisory Group.

Ngā karu a ngā tamariki hei matakite maungarongo mō te ao meāke nei.

The eyes of the children are the visions of the future.

Introduction

The New Zealand Psychological Society welcomes this ambitious document that recognises the complexity of child poverty and the need to address this issue on a number of broad fronts. There is already a wide range of information documenting the difficulties of child poverty and we are encouraged to see this report attempts to go beyond restating the problem to actively promoting solutions.

Our members are actively engaged in meeting the needs of those with mental health difficulties. The relationship between poverty and poor mental health is complex and it is mediated by variables that are themselves likely to be related to poverty e.g. child abuse, neglect, unemployment, gender, ethnicity, maladaptive coping strategies. However, the causal role played by poverty in a range of mental health problems has been well established, including depression, drug abuse and suicidality¹.

Although poor mental health can cause poverty there is increasing evidence that poverty is part of the causation of mental health problems.

Mental health is very closely related to many forms of

¹ Read, J. (2010). Can Poverty Drive You Mad? 'Schizophrenia', Socio-Economic Status and the Case for Primary Prevention. New Zealand Journal of Psychology, 39(2), 7-19.

inequality. The social gradient is particularly pronounced for severe mental illness. For example, in the case of psychotic disorders the prevalence among the lowest quintile of household income is nine times higher than in the highest. While the particularly high rate of psychotic disorder in the lowest quintile may, to some extent, result from downward social drift, this is unlikely to account for the social gradient².

Our members are also involved in supporting young people within educational and other institutions that promote their wellbeing. There is evidence for the link between low socio-economic status (SES) and low cognitive/academic attainment and a more complex relationship between SES and socio-emotional development of children. We note that there are likely to be a number of mediating variables, including (i) Resources such as nutrition; access to health care; housing; cognitive stimulating materials/experiences; parental expectations/styles; teacher attitude/expectations (ii) Stress reactions such as allostatic load (the physiological consequences of chronic stress); parenting such as negative control strategies, low warmth and responsiveness, and failure to adequately monitor children (iii) Health-relevant behaviours/lifestyle such as the use of tobacco and alcohol, diet and exercise. The ability to purchase goods and services is likely to interact with these mediating variables.

Those who live in poverty and its consequences are the 'experts' in the suffering that they and their communities experience.

In addition, our members are often called to attempt to remediate in situations where young people have been seen to transgress the rules or tikanga of their communities for example in the courts, young offenders and CYFS. Some of the findings from the Christchurch and Dunedin longitudinal studies would support the view that children growing up in the most disadvantaged households are likely to be facing multiple problems in later life e.g. conduct/oppositional disorder, police contact reoffending, cannabis use, alcohol abuse, substance abuse, mood disorder, suicide Ideation, low self-esteem, early sexual activity³.

Rates (%) of problem behaviours amongst the most disadvantaged 5% and the most advantaged 50% of the Christchurch sample:

Classification⁴ Most Disadvantaged 5% Most Advantaged 50%

Multiple Problem	21.6	0.2
At least one problem	56.2	18.5
Problem Free	13.2	81.3

Those who live in poverty and its consequences are the 'experts' in the suffering that they and their communities experience. However, psychologists are one of the groups of professional helpers who continually witness the suffering that these young people and their communities face on a weekly and often daily basis⁵. We are mindful that our Code of Ethics requires us not only to 'treat' the symptoms of our client's distress but work actively at an individual, local and national level for social justice⁶. This is not just of benefit to those identified as being in poverty but for the wealth and wellbeing of all sections of our communities in Aotearoa⁷.

Which proposals will be effective in reducing child poverty?

1. There is compelling evidence that the rise in child poverty in 1980s and 1990s was a direct result of government policies and in particular the reduction of benefits levels and increase in state house rentals and healthcare costs in the 1991 Budget. Improvements from 2004 to 2008 have been attributed to the Government's Working for Families package which was designed to support the low to middle class families with dependent children⁸. We would therefore support the proposals to change Family Tax Credit rates to give more money to families with young children or more than one child.
2. There is an increasing consensus that targeting resources for infants and young children is likely to be money well spent. We have been successful in Aotearoa/NZ in caring for our elderly via the consistent, universal and simple

4 From Christchurch total cohort n= 1265, 74.5% (n= 992) selected and 27 (2.7%) students retrospectively identified as multiple-problem adolescents at 15yrs.

5 Waldegrave, C. (2010). Global Poverty Special Editorial. New Zealand Journal of Psychology, 39(2), 5-6.

6 Code of Ethics Review Group. (2002). Code of Ethics for Psychologists Working in Aotearoa/New Zealand 2002: NZ Psychological Society, NZ College of Clinical Psychologists and NZ Psychologists Board.

7 Wilkinson, R. G., & Pickett, K. (2009). The spirit level: Why more equal societies almost always do better London: Allen Lane.

8 Davies, E., Crothers, C., & Hanna, K. (2010). Preventing Child Poverty: Barriers and Solutions. New Zealand Journal of Psychology, 39(2), 20-28.

2 The Marmot Review. (2010). Marmot's Fair Society, Healthy Lives University College London. The Marmot Review. p54

3 Fergusson, D. M., Horwood, L. J., & Lynskey, M. (1994). The childhoods of multiple problem adolescents: a 15-year longitudinal study. Journal of Child Psychology, 35(6), 1123-1140

payment of superannuation⁹. Therefore, we welcome the suggestion to introduce a new, but similar child payment that is a universal for young children and targeted for older children.

3. Acknowledging the low take up of Child Disability Allowance (CDA), we welcome strategies that ensure benefit/allowance systems are simplified and accessible.
4. Vulnerable young children will need high quality support from their whānau. We concur that the practicality of obtaining paid employment, particularly for sole parents will need to be balanced with the care needs of their children.
5. We note that a third of those living in poverty have a parent who is in work but whose income is insufficient. We agree with the need to make work family- friendly and to pay enough to enable parents to meet the needs of their children. This will require access to high quality early childcare support that is available at low or no cost.
6. Many of our clients are subject to unscrupulous lending practices and are often refused access to other means of managing debt. We support proposals to consider philanthropic lending opportunities and access to financial literacy.
7. Housing is likely to be the major expense for our clients. The quality of this housing is not only important in terms of children's health but also their ability to access high quality services to reduce the cycle of poverty.

"...families with more money, higher levels of education, and higher occupational status are likely to purchase an array of goods and services that directly benefit their children. High-SES families may also use their wealth to live in good houses in safe neighbourhoods, thereby affording their children protection from harm. The goods and services also become part of more elaborate paths involving chains of mediators (wherein particular goods and services may more indirectly affect child outcomes)".¹⁰

The short term nature of many housing options and the consequent lack of security can mean children fail to access education, health and other young person's services and therefore place them at higher risk despite the best efforts of psychologists and other professionals. We agree that high quality housing and the stability that

it affords will be a priority for alleviating child poverty in this country.

8. We agree that there should be a national strategy for providing food in low-decile schools implemented in ways that are sensitive to the risks of potential stigma
9. After-school and holiday programmes are ways to further enrich the experience for those who might have limited opportunities elsewhere.
10. We support the proposal for extra funding for youth-friendly school-based health and social services to mental health, sexual health, teen pregnancy, drug and alcohol abuse and depression (p33). We agree with the need for sustained funding for such projects that otherwise come and go with the consequent loss of expertise and trust.

There is an increasing consensus that targeting resources for infants and young children is likely to be money well spent.

Which proposals are less likely to be effective?

1. We applaud the separate attention given to the needs of Māori and Pasifika whānau in the interest of equity given the disproportionate effect of poverty on these communities. We agree there will need to be well-targeted measures to improve outcomes for Māori and Pasifika families that move beyond a deficit lens. We agree with the proposal that the government work with Iwi and Māori organisations to develop measures and indicators of Māori well-being that include Māori concepts of poverty and wealth.

However, within this report we wonder to what extent the Commission has been able to consult with Māori and Pasifika communities to framethtre the different conceptualisations of poverty within these communities. This is not intended to devolve all responsibility to them but to genuinely work in partnership with those communities. Durie encourages us to question 'the tendency of government publications to espouse Māori sentiments while providing nothing of substance to give effect to them'¹¹. We would predict that strategies that

9 Every Child Counts. (2010). Eradicating child poverty in New Zealand. Retrieved from http://www.everychildcounts.org.nz/_wp-content/uploads/2010/07/Child-poverty-resource-document-13.doc

10 Bradley, R., & Corwyn, R. (2002). Socioeconomic Status and Child Development. *Annual Review of Psychology*, 53, 371-399. p386

11 Cited Cooper, E., Rickard, S., & Waitoki, W. (2011). Maori, Psychology and the Law: Considerations for Bicultural Practice. In F. Seymour, S. Blackwell & J. Thorburn (Eds.), *Psychology and the Law in Aotearoa New Zealand* (pp. 35-61). Wellington, New Zealand: New Zealand Psychological Society, p 36

are formulated at an early stage with Māori and Pasifika communities are more likely result in their engagement and therefore in successful outcomes.

2. Service Hubs operating out of low decile schools to provide a range of wrap-around services such as teen units, after school programmes, holiday programmes would seem to be a good use of resources and utilise existing trusted relationships to give access to such services. There is a risk of potential underfunding of such services or reduction of funding after the initial adoption phase.

The teaching staff and support workers in low decile schools already bear the brunt of the challenges of poverty. Without sufficient numbers of well qualified, culturally competent staff such provisions are unlikely to be sustainable. It would effectively make such under-resourced interventions a type of window dressing.

3. We welcome the principle of devising a specific measure of child poverty in Aotearoa so that we can attempt to monitor our progress. However, given the complexity and the many mediating variables it is unlikely that any such measure will ever be complete or sufficiently comprehensive. We are mindful that this initiative might divert resources and energy from practical interventions. In addition to the macro level economic proposals, we hope that priority would be given to small scale, localised projects initiated and designed in collaboration with the communities that are seeking to prevent the cycle of poverty. We are encouraged by the six Social Sector Trials that you report in Te Kuiti, Kwarau, Tokoroa, Taumararui, Levin and Gore (p25). Our members have the expertise and experience to support and evaluate such projects.
4. We agree that it is desirable to have integrated public sector services as proposed for Māori and exemplified in the Whānau Ora approach. However, even the most effectively integrated health and social services cannot singularly alleviate child poverty. The large numbers and the intergenerational nature of child poverty will require attention to changing the social structures that keep groups of people powerless¹².
5. We agree with your cautious proposals for target setting for reducing poverty to help focus our efforts in a meaningful and collaborative way. We would caution against the setting of mandatory targets without very careful thought given to the unintentional consequences that might arise. For example reducing collaboration,

carrying out meaningless activity to meet targets and unwieldy accountability systems that divert resources away from those who need it most¹³.

6. We would support the proposal to evaluate Rangatahi Courts and increase government support for restorative justice initiatives which connect young people back into to their communities (p19). Again this would include some caveats recognising the critique by some commentators regarding the State's role in disproportionately penalising those in poverty and the potential for drift from whānau focused models to

Durie encourages us to question "the tendency of government publications to espouse Māori sentiments while providing nothing of substance to give effect to them".

professional-driven models¹⁴.

What is missing from the package?

1. Overall this report is very comprehensive in its attempt to address the issue of child poverty.
2. As psychologists we are interested in attitudinal change, the role of the media and systemic change. We note that unlike the elderly, young children may not have the advocacy that is required to promote the necessary political change and diversion of resources. We note that there is some evidence to suggest that New Zealanders are more likely to attribute the causes of poverty to individual failings (e.g. the poor are lazy) than systemic failings (e.g. the poor face unfair and discriminatory systems) for example, compared to the citizens of Sweden.

"Coverage took for granted 'common sense' ideas from contemporary society, including the notion that poor people purchase cigarettes or gamble instead of feeding their children. Primary emphasis was on the stereotypical notion that poor people often neglect their children and that children are innocent victims of neglect-resulting in child poverty. Coverage is constructed to appeal to the 'scroungerphobic' fears of middle New Zealand." (Barnett et al., 2007, pp. 305-306)¹⁵

13 Seddon, J. (2008). Systems Thinking in the Public Sector: the failure of the reform regime...and a manifesto for a better way. Axminster: Triarchy Press. p105

14 Cooper, E., Rickard, S., & Waitoki, W. (2011). Op. cit.e

15 Cited Davies 2010 op. cit. p27

12 Davies 2010 op. cit. p26

Any successful and sustained programme to alleviate poverty in Aotearoa/NZ will require the support of the general public so that the dissemination of funding is not subject to the vagaries of political ideologies. There is some limited evidence that these attitudes can be changed not by discussions about relative poverty or the use of statistics, but by appealing to the general public to consider children not having a warm coat, a birthday party, the increased number of children dying in poverty and an emphasis on the possibility of change.

End piece

Concern with child poverty is heightened partly because children are dependent and unable to look after themselves (so society takes a broader 'duty of care' attitude - looking over the shoulders of parents) and partly because adequate investment in their development is needed for the longer term good of themselves and the wider society¹⁶.

We are conscious of the mechanisms of 'moral panic' that accompanies a public outcry (e.g. the Mazengarb Report of 1954). After professionals and media have debated, such issues are often quickly forgotten as another matter fills the airwaves¹⁷. We are keen to see many of the recommendations made in this report enacted and ways to sustain ongoing progress found.

One way to begin to extend this beyond a temporary minority issue is to change the way we think about this matter. Rather than conceptualising this as a problem where we need to fix a 'deserving' group but more as an issue of the wellbeing of Aotearoa/NZ as a whole.

The solution to problems caused by inequality is not mass psychotherapy aimed at making everyone less vulnerable. The best way of responding to the harm done by high levels of inequality would be to reduce inequality itself. Rather than requiring anti-anxiety drugs in the water supply or mass psychotherapy, what is most exciting about the picture we present is that it shows that reducing inequality would increase the wellbeing and quality of life for all of us. Far from being inevitable and unstoppable, the sense of deterioration in social wellbeing and the quality of social relations in society is reversible. Understanding the effects of inequality means that we suddenly have a policy handle on the wellbeing of whole societies¹⁸.

16 Davies 2010 op. cit. p28

17 Cohen, S. (1973). *Folk Devils and Moral Panics*. St Albans: Paladin

18 Wilkinson, R. G., & Pickett, K. (2009). *The spirit level: Why more equal societies almost always do better* London: Allen Lane.p33

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Ka ora pea ki a koe, ka ora koe i au

Perhaps I survive because of you and you survive because of me


Grateful thanks to Quentin Abraham, NZPsS Director of Social Issues for leading the development of this submission.

New Zealand Psychological Society Annual Conference

6-9 September 2013, Auckland



The New Zealand Psychological Society
Te Hōkai Māori Hinegaro o Aotearoa




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John Forsyth, USA - more to be confirmed



Offender Volumes Report

The Department of Corrections has published its third edition of the *Offender Volumes Report*. The report documents information about the offender population managed by the Department of Corrections for planning and policy development purposes. Information in the report includes the following

- The average age of prisoners is increasing
- The proportion of prisoners held on remand has grown steadily in the last 13 years
- Prisoners serving long-term sentences (greater than two years) account for the majority of the increase in the prison sentenced population over the last two decades
- The number of offenders serving a community sentence or order has increased markedly over the last three decades.

Source: Meet the Man Behind the Offender Volumes Report Corrections News May/June 2012 p6

American Psychological Association Report on Diversity

The American Psychological Association (APA) has published a report titled *Dual Pathways to a Better America: Preventing Discrimination and Promoting Diversity*. The task force responsible for the report chose two primary premises on which to focus its work: (1) An enormous toll is exacted on human capital when systematic biases, stereotypes, and discrimination are perpetuated; and (2) acceptance of and support for social diversity is critical to the health of the population, especially in light of the fact that the diversity of the U.S. population is ever expanding. As well as looking at the harm of discrimination the report refreshingly looks at the growing body of evidence that indicates that diversity can be beneficial to achieving positive outcomes in education, business, and interpersonal and intergroup relations. The report also looks at the research which points to ways to overcome prejudice e.g. intergroup contact reduces intergroup bias and prejudice as does cooperative interaction and learning and retraining learned associations. This informative report can be accessed on <http://www.apa.org/pubs/info/reports/promoting-diversity.aspx#>

Spanking Children and Mental Illness

The American Academy of Paediatrics has released a study which supports their belief that spanking children is harmful to mental health. The study titled "Physical Punishment and Mental Disorders: Results from a Nationally Representative U.S. Sample" has been published in the August 2012 edition of *Pediatrics*. The study indicates that children who have been spanked, hit or pushed have an increased risk of mental health problems as they grow older. The aim of the study was to look at the impact of harsh physical punishment (i.e. pushing, grabbing, shoving, slapping and hitting) in the absence of more severe child maltreatment such as sexual, emotional abuse and physical abuse and emotional and physical neglect. The study found that harsh physical punishment in the absence of severe child maltreatment is associated with mood and anxiety disorders, substance abuse/dependence, and personality disorders in a general population sample.

Source

Afifi, T., Mota N., Dasiewicz P., MacMillan H., Sareen J. (2012). Physical Punishment and Mental Disorders: Results from a Nationally Representative U.S. Sample. *Pediatrics* 130 (2) August. <http://pediatrics.aappublications.org/>

DSM -5 Diagnosis- Dealing with Uncertainty

The latest revision of psychiatry's diagnostic manual is beset by controversy. *New Scientist* (19 May, 2012 pp 6-7) notes that the American Psychiatric Association has revealed that results from field trials of diagnoses proposed for the next edition of the *DSM-5* indicate some problems with diagnostic reliability. The trials sought to answer the question whether doctors would come to the same conclusions when assessing the same patients using the new diagnostic criteria. The reliability for some diagnoses was good but for others the scores were little better than chance. On the basis of the results two proposed disorders were relegated to the volume's appendix which lists those conditions requiring further study. The article notes

Critics argue that more might have joined them [those relegated to the appendix] had the APA not adopted a low threshold for what is considered an acceptable score for reliability.

In the United States in particular, the manual, which

is scheduled for publication in May 2013 will have an important impact on people's lives in varying localities by playing a part in who is given psychoactive drugs, whether in-patients are covered by health insurance or are held indefinitely in secure mental hospitals. For information on the evolving status of DSM-5 go to <http://www.psych.org/practice/dsm>

Under-treatment of mental health problems a concern in the United Kingdom

An article in the UK newspaper the *Guardian* (18 June, 2012) reported that in 2011 of the 6.1 million people with treatable anxiety or depression in England, only 131,000 entered talking therapy in the last quarter of 2011. A report titled "How mental health loses out in the NHS" published by the London School of Economics suggests that millions of pounds are being wasted and many people's mental health problems are not being addressed. The leader of the mental health policy group Lord Layard noted that talking therapies such as cognitive behaviour therapy relieved anxiety and depression in 40% of those treated, but that government funding to train more therapists was patchy with services for children being cut in some areas. Lord Layard noted that it was a real scandal that the UK had 6 million people with depression or crippling anxiety conditions and 700,000 children with problem behaviours, anxiety or depression and three quarters of each group got no treatment.

Layard also noted that "mental health is so central to the health of individuals and of society that it needs its own cabinet minister ... The under-treatment of people suffering from mental illnesses is the most glaring case of health inequality in the NHS ... Despite the existence of cost-effective treatments it receives only 13% of NHS expenditure. If local NHS commissioners want to improve their budgets, they should all be expanding their provision of psychological therapy."

For more information go to http://cep.lse.ac.uk/_new/research/mentalhealth/default.asp

Transformational Teaching and Learning

Associate Professor Neville Blampied has drawn our attention to an article featured in *Educational Psychology Review* authored by George M. Slavich and Philip G. Zimbardo titled "Transformational Teaching: Theoretical Underpinnings, Basic Principles, and Core Methods". Neville rates this as the most stimulating article that he has read on the topic of teaching and learning for a long time.

The article notes that classroom teaching and learning have evolved considerably over the past 50 years. This progress has been assisted by the development of a range of principles and methods of instruction including active learning, student-centred learning, collaborative learning, experiential learning and problem-based learning. Slavich and Zimbardo consider that these approaches share important underlying characteristics and can be viewed as complimentary components of "transformational teaching". The abstract to the article notes

Transformational teaching involves creating dynamic relationships between teachers, students and a shared body of knowledge to promote student learning and personal growth. From this perspective, instructors are intellectual coaches who create teams of students who collaborate with each other and with their teachers to master bodies of information.

This approach aims to enhance students' personal development and attitudes to learning by a range of actions including establishing a shared vision for the course, providing modelling and mastery experiences, challenging and encouraging, personalising attention and feedback and creating experiential lessons which transcend the boundaries of the classroom. The authors believe that such methods are synergistically related and promote intellectual and personal growth.

Neville notes that some of the theoretical perspectives espoused in the article could be critiqued. For example, material could have been integrated from the "rich cognitive research literature on learning and memory" but notwithstanding this caveat, this is a worthy article with useful summaries of different teaching techniques that can be used to enliven and improve learning and instruction.

Transformational Teaching: Theoretical Underpinnings, Basic Principles, and Core Methods. George M. Slavich & Philip G. Zimbardo.

Educ Psychol Rev

DOI 10.1007/s10648-012-9199-6

Pub> 24 July, 2012

<http://link.springer.com/article/10.1007%2Fs10648-012-9199-6?LI=true>

The Way of the Dodo

Alison Kirby



Alison Kirby is a New Zealand registered educational psychologist in private practice and the Director of All Poppies Ltd in Auckland. Alison spent 10 years as a registered nurse working in various intensive care units here and in the United Kingdom (neonate, paediatric and adult). She gained a BA (ED) and MA (Hons) in Education at The University of Auckland, before graduating from Massey University's PGDipEdPsych programme. She has been in private practice as a psychologist for the last 12 years.

The last Dodo may not have realised that extinction was looming but, unless some changes are made, the future prospects for educational psychologists in New Zealand are clear and dismal. We are losing the battle for recognition as valuable specialist professionals. We are thin on the ground, underpaid and somewhat marginalised by our own inertia to successfully adapt, to change; to deal with this malaise.

Dr Peter Stanley in his recent article, "The Future of Education" (*Psychology Aotearoa*, 2010) commented on the changes in education and the decline of the profession of educational psychology into a "parlous state" notes that "we need highly trained skilled educational psychologists like we have never needed them before" (pg 82, vol2, no 2, *Psychology Aotearoa* 2010). Several others have all drawn the same, dismal conclusion about the state of educational psychology, and its decidedly perilous future. Are we being replaced by pseudo-psychologists, or as one commentator put it, by "barefoot psychologists"?

Are there enough educational psychologists to meet public expectations and needs? Are we accessible or, for many, just too hard to get to? Is this because "that's how things are?" Do we actually believe that's OK? Could it be that, not having adapted and advocated, we have failed to achieve an effective presence and reasonable accessibility in the general public's eyes?

With a well publicised 20% tail of students not achieving as well as expected at school, if we did a random survey it would probably show that many of the public don't know we exist, what we do or how to contact one of us. If that is indeed so, we couldn't rest easy and consider that 'job done'; we'd really have to face up to the issue and do something to address this situation – or clearly risk joining the ranks of the extinct vocations mentioned by Stanley.

None of the other branches of psychology seem to be

anywhere near the sorry state educational psychology finds itself in today. Clinical psychologists are the most common variety of psychologist, counselling psychologists are also able to claim a good muster of members. There are far fewer industrial and organisational, and educational psychologists. While industrial and organisational psychologist's habitats are usually corporate in nature, educational psychologists are often found in the Ministry of Education or filling RTLB roles. Some very few of us have ventured into private practice.

Are educational psychologists the poor country cousins? We certainly are not on the same pay schedules as other psychologists. According to www.careers.govt.nz a clinical psychologist with nine plus years of experience can earn \$86,463 to \$97,832, a manager or professional advisor can earn \$98,000 to \$105,000. Industrial organisational psychologists are even better off. At the senior or management level (10 years' experience or more), they can look forward to \$70,000 to \$120,000. Those at director level (those who set up and run their own businesses) can earn up to \$170,000. Worse, these figures are a few years old now.

By comparison, educational psychologists with over ten years' experience, can reportedly earn up to \$83,209 in GSE. Those in the RTLB Service are earning between \$70,000 and almost \$75,000 per annum, but with a rather attractive holiday package of 12 weeks a year. As this is the same rate as senior teaching staff, the more cynical could be forgiven for concluding that, as both must also complete RTLB training, having an educational psychology qualification is of no more fiscal value than having a teaching qualification alone.

The private sector educational psychologist is reportedly charging between \$80 and \$135 (inc GST) per hour.

This means that many are actually making less than the average wage (for a Master's graduate in their first year) of \$50,000, and compared to the equivalent of the industrial organisational director level psychologists we're probably lucky to make more than a quarter of their (dated) earnings.

Congratulations to the educational psychologists, we're the lowest paid of the three groups. Is this because we have Overactive Generosity Syndrome (OGS) or do we have a Business Savvy Deficit (DSD)? Compared to the clearly more savvy IO psychologists we appear to be in significant need of help with this area of our profession. There seems to be very few educational psychologists willing to openly comment on job satisfaction, but anecdotally, this is poor.

In terms of the private practitioner, are we victim to the general public misconception that "its education, so it should be subsidised"? Are we caught in the trap of meeting public need because they can't get help elsewhere, and because many can't afford the realistic fees so we stick with undercharging?

While it may be true many families have no trouble in saying they can't afford a realistic private service fee many of these same families may well be prepared to pay the accountant, doctor, dentist or lawyer considerably more per hour for their services- so is this really about affordability or is this about our value? If we are under pressure because the government has apparently dropped the ball in providing public educational psychology services, do we aid the cause by providing private service at a cut rate price, or by doing so, do we in fact inadvertently aid and abet the trend towards the provision of barefoot psychology? Is the rise of the Level C assessor symptomatic of this trend?

If we don't see ourselves as equals to other psychologists in value, or to other professional bodies with lengthy training programmes it is no wonder we're in this position and it is no wonder we undercharge, and are an endangered species – why would anyone want to follow down this road? Stanley is unequivocal when he says "quiet clearly we need more [educational psychologists]".

While the Workforce Survey is voluntary, meaning that it may not reflect entirely accurate numbers of psychologists in the various scopes, this is nevertheless the only data published that I could find that attempts to quantify a breakdown of psychologist numbers by vocation. The latest workforce survey data (2009) from the Psychologists Board while dated, shows that there are a meagre 81 educational psychologists in the Ministry of Education, and 30 in private practice, with at most 4 in any other sector. Even if numbers are actually thought to be about 160 FTEs in the Ministry of Education, not all of these will be

registered as educational psychologists. There are still clearly relatively few of us practicing in this area, and so is it any wonder we're on the immigration hot list of sought after professions?!

Do we sit and wait meekly while the institution crumbles around us or do we need to help ourselves. Simply put, as a basic premise of any helping profession; if we are to help others we must first help ourselves. We need to step up in terms of our profiles and roles in education and development; we need to reassert why we can't be replaced and sidelined by barefoot or pseudo-psychologists. A crucial place to start would be to at least value ourselves as equals to other psychologists.

This means that in the case of the private psychologists we'd need to charge enough to cover overheads and taxes and still earn an equivalent salary recognising that the nature of our work necessitates significantly more report writing than some other psychologists might do per client. This report writing needs to be incorporated into our figures in real time terms not as token underestimations.

We need to charge out at a rate more akin to clinical psychologists – at least \$150+/hour face to face, but add real backroom time costs to this. This means acknowledging that for 4-5 hours of face to face time there is at least 3 hours additional time attached, meaning that in any 40 hour week we could see and complete an assessment for a maximum of 5-6 people.

If our current charge out rates in private practice are indeed the \$80-\$135/hour as advertised, then those achieving even close to a reasonable rate of income, are doing so by working well in excess of 40 hours a week. If they keep that up, like global warming, we'll reach a point of no return and bid farewell to those burnt-out by exhaustion, frustration and dissatisfaction. Are educational psychologists in government services any better off – are they paid at a rate commensurate to other branches of psychology?

We can accept the status quo and continue on down the 'no exit' road of extinction after the Dodo, or alternatively we could reassess our predicament, adapt and develop as a profession. The next move rests squarely in the hands of each of us; the educational psychologists. We need to ask ourselves "are we equal to other psychologists?" Are we worth it? And, if we are, what are we going to do about it? Perhaps more importantly what does that mean you'll do? We could each wait for someone else to do something, but then continuing to do nothing didn't turn out so well for so many of those other long dead vocations- now did it?

Boat People, Public Policy and Humanitarian Alternatives to Detention

A Policy Paper from the Refugee Council of New Zealand

By G.E. Poole, CEO, RASNZ – Diversity Health, and Dr Arif Saeid, Vice President, RCNZ



Gary E. Poole has served as Chief Executive of RASNZ, the refugee health agency since 2006. He had previously served for two years in a leadership role with the FOCUS Development Network in Afghanistan on UNHCR programmes in building hospitals and establishing humanitarian services and

evaluation. A registered psychologist, much of his career has been in management of public health services, NGOs and humanitarian aid and development work based in Hawaii, Malaysia, Cambodia, and Cameroon. Earlier in New Zealand he had established regional child and family centres, aged care, addiction treatment, and community development initiatives as general manager for Presbyterian Support. Gary is a member of the executive of the Refugee Council of New Zealand, and of the international UNOHR Human Rights Council. He has carried out research projects for the UNODC in Nepal, Thailand, and Tajikistan. Together with the Waitemata DHB, in 2008 he initiated the CALD (Cultural and Linguistic Diversity) national training for NZ health practitioners.



Dr Arif Saeid is Vice President of the Refugee Council of New Zealand and Manager of Community Services for RASNZ, the refugee health agency. Arif grew up in Herat, Afghanistan and trained at medical school in the national university at Jalalabad. Appointed as a doctor for *Medicins Sans Frontiers* (MSF), he practiced medicine in

the border province of Oruzgan. Arif married Dr Fahima Saeid who was the only woman superintendent of a hospital during the period of the Taliban. They established pioneering health services for women and children, and worked to improve public health and survival rates. Arif and Fahima were forced to escape Afghanistan with their four children and temporarily settled as refugees inside Pakistan in 1999. Arif and his family arrived in New Zealand as refugees to resettle in 2000. Unable to practice medicine in NZ, Arif re-trained in counselling with the University of Auckland. He set up the Community Health Facilitators team for RASNZ at the National Refugee Centre at Mangere. He also initiated the Refugee Road Safety Action programme, smoking cessation programmes, and training in health promotion. He has served as the consultant to the RASNZ clinical teams on treatment and rehabilitation of survivors of torture and trauma. Arif was one of three New Zealand representatives to the UNHCR Tripartite Consultations in Geneva this year.

With the introduction of the proposed Immigration Amendment (Mass Arrivals) Bill by the National Government in May of 2012, refugee issues have for the first time become politicised in this country. This discussion focuses on the research around involuntary detention of asylum claimants under the UN Refugee Convention, and what New Zealand can learn from the recent Australian experience. There is evidence that the involuntary long term detention of asylum claimants seriously damages those affected, but it also equally brutalises the people and the societies carrying it out. By preparing well in advance for what many people believe will be an inevitable sea arrival, and by implementing best practice models prior to that event with the present asylum seekers coming by other means, New Zealand can positively demonstrate its international leadership in humanitarian principles applied to the increasingly complex issues of irregular migration.

Introduction – Migration as a Political Issue in the 21st Century

In developed Western countries immigration has become increasingly intertwined with politics due to contemporary public concerns about national security, border control, and fear of terrorism, as well as social issues around cultural diversity and tolerance. New Zealand is no exception, and the recent passing of significant reform legislation in the Immigration Act 2009 was partly in response to asylum issues, court cases, and related controversies. International and domestic concern about Australia's recent wave of boat asylum seekers has also provoked public policy debate on this side of the Tasman.

Why Governments Detain Asylum Seekers and Intending Irregular Migrants

Underlying reasons (Field 2006) why governments around the world detain irregular migrants include:

- Deterrence of future asylum seekers or irregular migrants from making attempts to enter
- Providing a sense of control over territorial borders
- Responding to political pressures and concerns of segments of the public
- In relatively rare cases, addressing identity or genuine security issues

Control of its own borders is a key test of the sovereignty of a country and a necessary and essential responsibility of government.

Questions about identity, false documents, or genuine security concerns are certainly valid and accepted reasons for detention or restriction of movement of a person in an irregular arrival situation. Beyond the small number of such genuine cases, political pressures often come to bear, and politicians particularly cannot be seen to be losing control of borders or flows of migrants into a country, as opposition parties will often seize upon the issue. This phenomenon was observed in the recent Australian elections. A further, tacitly implied underlying broader reason that governments detain asylum seekers is because of concerns about the risks of absconding into the general community. Whether this is a valid concern supported by the evidence is clearly challenged by Field (2006) and other studies.

For New Zealand, the actual numbers of asylum seekers have actually generally decreased over the past five years as shown in Table 1. The reasons for this decline may possibly be attributable to a number of factors,

including enhanced pre-flight screening or interdiction at foreign airports. As Australia is considerably more accessible by boat and thus vulnerable to increased organised people-smuggling activities, the issues faced by politicians and public officials there have been challenging, and quite unlike the comparable situation of very small numbers of asylum seekers arriving in New Zealand.

Table 1. New Zealand Asylum Refugee Claims

YEAR	NUMBER OF CLAIMS LODGED	NUMBER OF APPROVED CLAIMS
2004	580	208
2005	348	209
2006	276	145
2007	248	113
2008	254	128
2009	319	93
Total	2025	896

Source: Immigration NZ (2009)

Anyone who has ever sailed on the Tasman Sea will attest as to how it presents a formidable natural barrier. But recently, political leaders are warning that a ship with asylum seekers may eventually make its way into New Zealand territorial waters (NZ Herald 2010). If or when that does occur, how prepared New Zealand will be to uphold international humanitarian standards and best practice with regard to the accommodation and processing of asylum claimants is presently an open question.

Evidence of the Detrimental Impacts of Involuntary Detention

In an overview of the research evidence, Murray, Davidson and Schwietzer (2008) cited a number of key studies on the psychological vulnerabilities of refugee claimants who have been held in immigration detention. They cite Thomas and Lau (2002) who conducted an extensive review of local and international research into the mental health status of children and adolescents detained in the course of claiming refugee status. Found among children in detention were disturbingly widespread levels of social withdrawal, regressive behaviours, flashbacks, sleep disturbance, developmental delay, nightmares and conduct problems.

Beyond the small number of such genuine cases, political pressures often come to bear, and politicians particularly cannot be seen to be losing control of borders or flows of migrants into a country, as opposition parties will often seize upon the issue.

Dudley (2003) estimated the rates of suicidal behaviours among men and women in Australian detention centres as approximately 41 and 26 times the national average, respectively. He further reported male refugee claimants in detention have rates of suicidal behaviour that are 1.8 times higher male prison rates. Steel et al. (2004) assessed parents and children who had been held in Australian immigration detention centres for approximately two years, finding all meeting psychiatric diagnostic criteria.

Mares and Jureidini (2004) confirmed high levels of ongoing psychological distress among adults and children in detention and noted that there was very little support and few interventions provided in such settings. Murray et al (2008 page 11) observed: “the detention setting places many obstacles in the way of clinicians servicing detainees and making significant improvements in such an impoverished environment is improbable.” Documented experiences of refugees in detention have offered compelling evidence that it impeded efforts to address their mental health needs, including for confirmed victims of torture as reported by Mares and Jureidini (2004).

The Australian Psychological Society submission (Allan, et al, 2008) to the National Inquiry into Children in Immigration Detention reached similar conclusions. The submission maintained that (p38) “holding young people in immigration detention is a negative socialisation experience, accentuates developmental risks, threatens the bonds between children and significant caregivers, and seriously limits educational advancement.” The detention experience has traumatic psychological impacts which Silove, Steel, and Mollica (2001) aptly described in *Lancet* as an assault on health, human rights, and social development.

New Zealand Policy and Practice in the Detention of Asylum Seekers

The majority of asylum seekers arriving in New Zealand are not detained for any length of time at any stage INZ (2010). A few, however, (Table 2) are held in correctional facilities (Auckland Mt Eden Prison Remand Centre) because: individual failed refugee status and assessment as liable to abscond; criminal charges; identity issues; and rarely, perceived security risk. Essentially, our New Zealand system operates on a sliding continuum of four options: detention in prison, limited detention or restricted movement at the Mangere Accommodation Centre (MAC), Conditional Community Release; or Unrestricted Release. People claiming refugee status are usually issued work permits for the time it takes to decide their status claim. Under the new 2009 Act, (INZ 2010) a person liable for monitoring or detention has reporting requirements and could be subject to initial arrest up to 96 hours by Police or pursuant to warrant up to 28 days with release on condition by the Courts. As of 1 November, 2010 legal aid became available for Asylum Seekers

challenging their detention in a Court under the new Immigration Act (DOL, 2009 Immigration Act).

Found among children in detention were disturbingly widespread levels of social withdrawal, regressive behaviours, flashbacks, sleep disturbance, developmental delay, nightmares and conduct problems.

The 2008 report of the UN Chief Inspector Crimes and Torture Act on New Zealand, gave New Zealand a generally good report card. No evidence was found that Asylum Seekers had been subjected to torture, or cruel treatment. Asylum seekers were found well-cared for in a good standard of cleanliness at the Mangere Centre; and were provided with comprehensive information about rights and entitlements.

Table 2. NZ: Asylum Detention – 2004-10

Source: Immigration New Zealand, Department of Labour

Fiscal Year	Detained MAC	Detained Prison	Total Detained
2004-05	62	14	76
2005-06	58	12	70
2006-07	34	4	38
2007-08	18	8	26
2008-09	16	6	22
2009-10	11	6	17

Comparatively, New Zealand had been recognised as a leading country generally having a record of endeavouring to consistently apply fair, just, and humanitarian principles in asylum issues. There are, however, some well-known key areas for necessary and immediate improvement. The Refugee Council of New Zealand (2010) has expressed the strong view that there is never any justification for holding any person seeking refugee asylum under the UN Convention in a prison or correctional facility if they have committed no crime.

Further, because of our remote geographic location, New Zealand has not yet had to contend with large numbers of boat arrivals or people smuggling operations as currently experienced in northern Australian territorial waters. Yet, many of the people seeking asylum are so desperate to escape the dangers and conditions in their countries of

origin or transition that they will risk their lives to seek any safe haven. If the future predictions of boat arrivals eventually prove correct, how prepared will New Zealand be to receive them and humanely respond? How will New Zealand continue to uphold its international reputation for fairness and humanitarian practices under similar pressures as faced by Australia?

Alternatives to Detention and International Models of Best Practice

The United Nations High Commissioner for Refugees (UNHCR) organised a Forum on Alternatives to Detention in Seoul, Republic of Korea in April, 2010, which was attended by representatives from governments and civil society of six countries, including New Zealand. During the Forum, the numbers of asylum claims, comparative practices and policies of a range of countries were reported and considered.

Some key findings and conclusions (UNHCR, 2010) presented at the Forum:

- Asylum seekers and irregular migrants are better able to comply with requirements if they can meet their basic needs while in the community. Good community case management is most essential, and also generally less costly.
- Asylum seekers and irregular migrants very rarely abscond while awaiting the outcome of a status claim or visa application while in the destination country if they are humanely treated and provided with basic living assistance, and case management support
- Detention should be the last resort in line with international best practice standards

Sweden, Canada, Norway and Finland were cited as examples of countries with best practice models in the community placement of asylum claimants without detention UNHCR (2010). Hong Kong, with its porous borders, reported more than 3286 asylum claims pending, but nearly all are managed in the community rather than in detention UNHCR (2010).

Under the AVR [Assisted Voluntary Return] programme, asylum seekers who have failed in their refugee status determination, or who choose early voluntary repatriation are case managed, counselled, prepared, and given moderate assistance to return to their country of origin.

Field (2006) conducted for the UN a major global comparative study relative to detention policies and absconding rates between countries. The range of findings

showed that absconding rates were consistently very low with the application of humanitarian and community case management approach models. New Zealand was cited in the study (Field 2006) and it was noted that of 159 detained at the MAC from 2001 and 2006, no one had to be transferred to the remand prison as a result of absconding.

Even when asylum claims fail (as in over of 50% of cases) Field (2006) finds that asylum seekers are likely to comply with a negative refugee status determination or removal order if:

- They have been through a fair determination process
- They have been informed, supported and properly case managed through the process
- They have explored all options to legally remain
- They are prepared and assisted for voluntary return to their country of origin

Assisted Voluntary Return (AVR)

Assisted Voluntary Return (AVR) is a promising new approach which has been piloted in several countries through the International Organisation for Migration (IOM 2008). Under the AVR programme, asylum seekers who have failed in their refugee status determination, or who choose early voluntary repatriation are case managed, counselled, prepared, and given moderate assistance to return to their country of origin. This is a system which should be considered for a pilot programme in New Zealand. Positive outcomes for irregular migrants and reduced costs for the host countries have been reported (IOM, 2009) in relation to the results of AVR.

Preparing for a Future Asylum Crisis Response Founded on Humanitarian Principles

How can New Zealand best prepare for a time when significant numbers of asylum seekers or Convention Refugees may eventually arrive by sea? What can we best learn from the experiences and mistakes of our neighbours and of other countries? How can we uphold humanitarian principles (IDC, 2008) and apply the best of international practice?

Specific Findings and Recommendations:

New Zealand should learn from the recent serious mistakes made by the Australian Government around the boat people issue and avoid repeating them. There is plenty to be learnt.

DO's and DON'T's

- DO engage in a well-informed, rational debate on what should happen in the event of a boat arrival in New Zealand territorial waters well before it actually occurs
- DO avoid allowing the issue to become a highly charged and divisive political football
- DO engage in bi-partisan, multi-party discussions to agree in principle what should happen when a boat eventually arrives. Base this on international best practice and the humanitarian principles for which New Zealand is internationally known
- DO have a clear, effective, transparent plan in place to process and accommodate those arriving
- DO have in place accommodation, medical care, legal assistance and the proper mechanism for rapid processing of any asylum claims under international and domestic law
- DO treat the arrivals humanely, courteously and with respect. Treat asylum seekers as you would wish to be treated yourself if you had to flee your country
- DO provide rapid processing of claims and don't leave asylum seekers in limbo or languishing in detention for long periods of time
- When a claim has failed and appeals are exhausted, act rapidly and fairly to try to achieve a voluntary repatriation or transfer, with deportation as a last resort
- DON'T put asylum seekers in fenced detention centres in the isolated rural areas
- DON'T put women and children in detention at all – it harms them

seriously and the society doing it

- DON'T keep asylum seekers in detention for long periods at all, research and experience around the world shows that community placement works best for all concerned
- DON'T use hapless refugees to score political points or for scaremongering purposes
- DON'T expect that putting asylum seekers in detention will have any effect at all on deterring others from coming – the overwhelming evidence shows it doesn't and it won't
- DON'T be closed to moving forward with a sound plan based on bi-partisan consensus, or try to take full charge and do it your own way because you're in power and you can
- DON'T ignore the advice of UNHCR and resource experts in the field

Rather than simply tacitly following the detainment centre reaction, it is argued that innovative and alternative methods are better, more effective and less costly. Subsequent to careful screening, and processing, a combined community placement and/or low security accommodation facility approach offers the superior solution for a range of reasons including practical, humanitarian and cost advantages. Being well-prepared with detailed contingency plans and well-trained teams will allow for a smooth transition, positive experiences for asylum seekers and better outcomes for New Zealand. Ad hoc responses to an unplanned emerging situation typically result in bad policy and inhumane practices.

The evidence is well-established that the involuntary containment of human beings seriously damages

those affected, but it also equally brutalises the people and the societies carrying it out. The analogous historic context in the ending of indigenous land confiscations, or the ending of suppression of the Māori language, or, in more recent times, the ending of pre-dawn immigration raids on Pacific Island communities by governments are all inescapable parallels. When such practices are ended, civil society is strengthened and civilisation advances.

By preparing well in advance for what many people believe will be an inevitable sea arrival, and by implementing best practice models prior to that event with the present asylum seekers coming by other means, New Zealand can positively demonstrate its international leadership in humanitarian principles applied to the increasingly complex issues of irregular migration.

DON'T expect that putting asylum seekers in detention will have any effect at all on deterring others from coming – the overwhelming evidence shows it doesn't and it won't

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Tumeke Bro'?

A Personal Reflection of a Male White Counsellor Working with Male Māori Tamariki

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This article was first published in the *New Zealand Journal of Counselling Vol 31 (1) 2012* and is reprinted with the kind permission of the editors.

Abstract

This article was born out of reflecting on my relationships formed with Māori male tamariki as a White male counsellor. How possible is it for a Pākehā to be an effective counsellor with Māori tamariki? Or is the space between us too big to bridge? In addressing this question I explore and reflect on the implications of White privilege, and its effects on the space in which I meet with tamariki.

Personal insights from reflecting on Māori concepts, the Treaty of Waitangi and my own culture and past confirm that yes, Pākehā can counsel Māori tamariki if they acknowledge the influence of White privilege in society, including in the counselling room; reflect on their own culture and past; are genuinely open, curious about and respectful toward Māori culture and language; and engage with the principles of the pōwhiri process in navigating their way through the space that invites both into respectful and safe relationship.

"Bro', you look Skux." I look at the young Māori boy standing next to me and laugh, a little awkwardly you would have noticed had you happened to be paying attention to us. "Umm thanks. What does that mean, bro'?" I say. "Don't you know, bro'? It means you got style," he says, educating me. "You too, my man, you too," I say.

I invite you to take a minute and think about your response. In what way did your cultural lens tint what you thought was happening? What bias do you think you might have had toward either of us? Was one of us more powerful than the other? Did any negative feelings or views come to your attention? What was positive in what you saw and heard?

Tumeke bro', or too much bro'? Is the space between us too big to bridge? I believe the answer is in the relationship (Durie, 2003), and that answer is no—the space between us is a space that invites each of us toward the other in unique ways. Durie (2003) and

Drury (2007b) invite us to consider how aspects of the pōwhiri, the rituals of encounter, guide the ways in which we enter and negotiate this space.

In this article I reflect on my experience of counselling cross-culturally with Māori tamariki (young people) for a community trust in a low socioeconomic area where my job takes me into five decile-1 schools. Often, tamariki who are referred for counselling present with complex emotional and behavioural problems and severe anger and verbal aggression, which have affected their interactions with adults and peers. These are the precious and often misunderstood boys with whom I attempt to form a therapeutic relationship. Some are Māori, others are Pasifika, and a few are Pākehā.

This article focuses on my work with the Māori tamariki.

Because of the work I am doing I believe it is essential to reflect on how being White shapes my understanding of the counselling process. How is White privilege at work here? Māori customs, values, beliefs, and philosophies offer essential insights for my work with my clients (Drury, 2007b). How can I continue to reflect on and integrate these in the work I am doing? Similarly, how does the Treaty of Waitangi impinge on who I am as a Pākehā male? And how do the principles of protection, participation, and partnership inform the ways in which I join with Māori in building therapeutic relationships? (NZAC, 2002).

He aha te mea nui o te ao? He tangata! He tangata! He tangata!

What is the most important thing in the world? (I would say) it is people, it is people, it is people.

Join me as I explore some of my own assumptions about race and identity,

and recognise how understanding where I have come from and where I am going could be a key to being able to work effectively cross-culturally as a counsellor in the present (Addy, 2008).

Because of the work I am doing I believe it is essential to reflect on how being White shapes my understanding of the counselling process.

The “invisible elephant” in society: White privilege

Ancis and Szymanski (2001) noted that the privilege of being White is rarely critically examined and reflected on by White people. To acknowledge that, from birth, White people have certain rights that are only due to the light colour of our skin leads many to react with feelings of defensiveness, discomfort, denial, and anger (Addy, 2008). To be White means that we often assume we speak on behalf of humanity, yet when a different race speaks they are often seen as speaking for their race or community, and not for humanity in general. An example of this would be when Don Brash, former leader of the ACT Party, spoke of one rule for all people regardless of race. Whether or not he had consulted “all” people seemed to be secondary to his assumption that he was able and entitled to speak for all. Yet when the Māori Party’s Dr Pita Sharples speaks, people tend to hear him speaking only for Māori.

The privileges of being White are said to be so ingrained in White culture that they are often invisible and unacknowledged by White people (Akamatsu, 2002). A study by Ancis and Szymanski (2001) assessing the awareness of White privilege among White counsellor trainees found that most had only a limited awareness of how being White often leads to a privileged and powerful position

in society. Frequently, “whiteness is unquestioningly seen as the human norm, and race is something applied to non-white peoples” (Addy, 2008, p. 10).

When I was just beginning my role at the Trust, I remember wondering at times why it seemed that I was asked a lot of questions as if I was an “expert,” when my Māori wāhine (female) colleagues had a lot of experience and knowledge on the topics they were seeking answers about from me. Could it be White privilege subtly subverting our relationships? Possibly. However, a wise Māori wāhine broadened my view, perceptively noting that “Māori often engage in circular conversations as a respectful way of connecting with people and to gauge where that person is coming from. The search for information is not always about finding out the best or most expert answer but simply to see if that person can be trusted to work alongside of and to work for and with Māori.” Two questions are worth reflecting on, however: “Can I be wrongly elevated simply due to my colour?” and “Do I contribute negatively to this myself?” I would have to say that if White privilege exists, and I believe it does, the answer to both is yes.

The ‘invisible’ elephant from Aotearoa New Zealand’s past

When we reflect on New Zealand’s colonial history, Māori have been required to fit in to White or Pākehā culture and systems in areas such as education, health care, and justice (Addy, 2008). Pākehā encouraged this one way, or “White way,” of living together that rejected Māori language, customs, and beliefs, leading to anything Māori being seen as inferior to everything European (Consedine & Consedine, 2005, as cited in Addy, 2008). As a consequence of colonisation, Māori account for a

disproportionately high number of people who are unemployed, incarcerated, and suffering from poor health (Durie, 2003; O'Connor & Macfarlane, 2002). As Durie (2003) has pointed out, Māori need to be able to live as Māori, which means access to language, tikanga (traditional customs), marae (the meeting area or focal point of whānau or iwi), land, whānau (family), and iwi (tribe), and not as Pākehā. Similarly, in a dialogue on tikanga and ethics (Lang & Katene, 2007), Kahuwaero Katene says that in “the past Māori have been encouraged to define themselves in Pākehā terms. The requirement for Māori has been to become bicultural, which has meant being bilingual at home and school, and bi-national as Aotearoa and New Zealand” (p. 38). Durie (2003) observed that after World War II, when Māori families moved from rural New Zealand into the cities in search of higher pay and subsidised housing, Māori instead became a new class of urban dwellers—poor, unhealthy, more at risk of committing crime, achieving poorer results at school, and living in substandard housing. Thus, one result of the urbanisation of Māori was the continuation of Māori being encouraged to define themselves in Pākehā terms, so that “being Māori was measured more by deficits in comparison to Pākehā middle class than by any notion of a secure Māori identity” (p. 91).

From an educational view, Drury (2007b) pointed out that he has encountered a number of Māori practitioners struggling to fit their knowledge of Māori into non-Māori paradigms learnt while studying for a qualification. Waldegrave (1998) and Drury have both ironically observed that indigenous people wanting to work in the helping professions can be required to leave their own people and values to study under people

with different values in order to gain a qualification so that they can go back and work with their own people. Waldegrave has warned that this type of learning process could disable indigenous, cultural “insiders” in their work to help their own people. O'Connor and Macfarlane (2002) pointed out, however, that Māori values of respect for other ways of knowing and bridging across cultures can guide us in how to be open and respectful of difference. They identified three values:

The first of these is tika or justice, the plea for cultures to “listen” to each other and hear each other’s voices. The second is pono, which refers to affirming the integrity of traditional, as well as contemporary, knowledge. Finally there is aroha, that concept which has depth and scope in abundance, but with a central core referred to as acceptance and compassion. (p. 232)

The ‘invisible’ elephant in the counselling room

In light of what we have reflected on so far, the question becomes

Two questions are worth reflecting on, however: “Can I be wrongly elevated simply due to my colour?” and “Do I contribute negatively to this myself?”

“How does White privilege affect the counselling process cross-culturally?” Wiggins Frame and Braun Williams (2005) point out that many counsellors and counsellor educators have underestimated the reality of White privilege in the profession, suggesting that this has resulted in unintentional racism. They observe that such counsellors and educators are “hampered by their own eurocentric and monocultural positions” (p. 172). One example of my being “hampered” by my Whiteness occurred during an art therapy session with one of my Māori

tamariki clients. He had previously done some great art work about his heart being bigger and stronger than the monster, his anger, concluding that “his heart always wins.” In this session, however, I had invited him to draw whatever he wanted to. He liked this freedom and proceeded to draw the land, the sea, and the beach. I noticed that he had really focused in on what he was creating, so I chose to sit back and not ask any questions. After some time, he said, “Finished.” I looked at his picture and asked him if there was anything he wanted to share about it. He replied, “Nah, not really.” I remember thinking at the time that maybe he just drew nothing in particular and I questioned myself about whether I was trying to read too much into it. I decided to ask him if there were any words he would like to write down on it that described the picture. He wrote “Peaceful.” At the time I thought it was a connection to his past drawing of his heart winning and peace being restored, but there was so much more there. Now that I am aware of the strong connection

of land and sea to Māori identity (Durie, 2003), I can see in hindsight that he was connecting and processing at a level I couldn't fully appreciate due to my lack of awareness. I also missed an opportunity to assist him in strengthening and exploring his unique connection to the land and the sea, and the meanings that this peaceful place held for him, representing much more than I first thought. As Durie (2003) has reminded us, most Western counselling theories presume that insight is achieved through looking inwards and probing memories, attitudes, and thoughts, whereas Māori

belief is that this is achieved by looking outwards through the relationships we have with the whānau, marae, land, and wider society.

White paua—addressing the power differential

The subtle and invisible work of White privilege, unintentional racism, and ethno-centrism can sabotage therapeutic relationships. Addy (2008) noted that when you add these elements to the position of power that a counsellor already occupies in counselling relationships, you have a power differential that can obstruct a counsellor's ability to work effectively cross-culturally. In my work with Māori tamariki, I am sensitive to the way in which my Whiteness positions me in the eyes of the young people while we are negotiating our relationships. Their comments often reflect assumptions about socioeconomic differences: that because I am White I am rich, have had an easy life, have expensive clothes, drive nice cars, and don't go hungry.

One technique I use to try to diminish the power differential between us and challenge some of their assumptions is to hand over the question-asking to them. This process takes into consideration the notion of "time, space, boundaries and circularity to the counselling process" (Durie, 2007, p. 6). They can ask me anything they want and I will answer them. For example, a young client kept asking me what I ate, what I did at home, and how I grew up, making assumptions that I "had it sweet" by actually answering some of his questions on my behalf with the famous "I bet you had...I bet you didn't have to..." As I answered his various questions, I was aware that even though we seemed to live in different worlds — he had 15 people in his house and I have four; he

babysits his cousin's kids while being a kid himself, while I am learning how to care for my wife and my new baby girl; he eats KFC every night and I haven't had it for three years (okay, one year)—many of my life experiences were similar to his. These include parents being divorced, alcohol abuse, living in state housing, feeling sad, and feeling alone.

In my work with Māori tamariki, I am sensitive to the way in which my Whiteness positions me in the eyes of the young people while we are negotiating our relationships.

As he asked more questions, I began to see that he was evaluating my answers in relation to his own experiences. In his own way he was applying the notion of tapu, or assessing risk, and whether our relationship could be noa, or safe, for him (Durie, 2010). Once he began to become aware that I too had parts of a story that resonated with his, he could see that he was not alone in this and that here was someone who, in some way, understood parts of his story in a way he hadn't thought possible just minutes before. In this manner, space, time, and boundaries were respectfully negotiated by each of us on our own terms. Our conversation also encouraged and respected the centrifugal direction of psychological energy by encouraging a "type of communication that alludes to but does not necessarily focus on a detailed point" (Durie, 2007, p. 6).

Paiheretia or the relational approach to counselling

A Māori-centred approach to counselling as defined by Durie (2003) puts greater importance on the relational aspect of counselling, as opposed to the focus from most mainstream therapies on overcoming a particular problem, either behavioural or emotional, by acquiring a particular

set of skills. This latter focus is seen "to be inwards and downwards, to the relative exclusion of the wider world and often with inadequate recognition of culture as a force for change" (p. 48). Paiheretia, or relational therapy, takes into account the four fields of experience: physical, social, mental, and spiritual. The focus of paiheretia is to "develop a secure cultural identity, establish balanced relationships with whānau and society, and achieve a sense of reciprocity with the wider social and physical environments" (p. 50). As Durie explained, this relational focus reflects the Māori belief that awareness, knowledge and personal understanding develop from outside the individual as opposed to from within.

Insights from the pōwhiri process

Being familiar with the pōwhiri process is fundamental for non-Māori counsellors in building relationships and enhancing the working alliance with Māori clients. The following seven steps to the pōwhiri are summarised and adapted from Drury (2007b).

Mihi: The forming of the therapeutic relationship. We discuss the reason for our meeting, focus on strengths by acknowledging the client's mana, and attempt to have equal standing so that no one is overpowered by the other. The application of tapu and noa to the relationship negotiations begin here, either consciously or unconsciously (Durie, 2010).

Karakia: Being open to the divine. Humility by both people in the relationship fosters opportunity for both to experience a transcendence beyond their own egos and to welcome the "yet to be known" about the self and each other.

Whakapuaki: Bringing that which was not visible into a

place where it can be known. The counsellor is encouraged to share his or her responses to the client's stories, creating a relationship that fosters the possibility for each to be changed by the other.

Whakatangi: Emotional shift or expression. Through the sharing and retelling of stories by the client, and the counsellor's own response to what has been shared, both are affected by the process and are now, in some way, different from who they were before.

Whakarata: The act of physical contact. Normally this can be through a hongi, the shaking of hands, or a kiss. With my Māori tamariki, we normally high-five.

Whakaora: Restoring wholeness, and reflecting on how new ways of being might be enacted in relationships with others and the wider community. Both the counsellor and the client can share what these changes mean for them now from their unique perspectives. There is also an opportunity to reflect on those who have gone before us and their awareness of holistic ways of being. As O'Connor and Macfarlane (2002) observed, for "Māori, the past is inextricably woven into the present and future, and departed ancestors (tipuna) remain present in spirit (wairua) (Doig, 1989, p. 17), available to provide psychological and spiritual nurturance and guidance" (p. 225). I have often heard tamariki speak the words of beloved papas and grandmas from the past, nurturing and guiding their grandchildren in the present.

Whakaotinga: "A covenant of maintaining the new way of being beyond this pōwhiri" (Drury, 2007, p. 16). The concepts of mutuality and reciprocity between client and counsellor are fostered and point to the celebration of changes that have

occurred. This can lead to the sharing of a meal, which I have often done with some of my Māori tamariki in our last session before the term break. We reflect on our time together, what we have learnt about ourselves, each other, and the world, and celebrate the relationship we have with each of these.

The Treaty of Waitangi and how I view myself as Pākehā

Snedden (2005) noted that it was the Māori Land Court Judge Eddie Durie who "first described Pākehā as tangata Tiriti—those who belong to the land by right of the Treaty" (p. 59). Māori, on the other hand, are tangata whenua, the original people of the land, and belong to the land because of this (Drury, 2007b). "Durie argues that as a Bill of Rights for both Māori and Pākehā, the Treaty places obligations upon both parties to form a partnership that benefits the community" (Drury, 2007b, p. 9). As Snedden (2005) rightly reminds us, it's Pākehā's Treaty too. This is a point that I need to reflect on further as a New Zealander—that I belong to the land by right of the Treaty and that I am obligated to form a partnership with Māori that benefits the community.

One technique I use to try to diminish the power differential between us and challenge some of their assumptions is to hand over the question-asking to them.

The NZAC Code of Ethics (2002) also charges counsellors with the responsibility of understanding and acting on the Treaty principles of protection, participation, and partnership with Māori. Undertaking more research and reflection on the Treaty and how I might better reflect these principles in my work as a counsellor—and as a Pākehā New Zealander in the 21st century—is part

of a continual, reflexive process of exploration, reflection, understanding, and action. As Addy (2008) noted, "Culturally sensitive counsellors have a set of attitudes and beliefs that grow out of self-awareness, a sense of self as a cultural being, and insight into the dynamics of their own cultural realities" (p. 18). I agree wholeheartedly with those who argue that, similar to Māori, Pākehā need to know:

where you come from, who you belong to, what your history is, what your reflexes are, what are the ways that your family does things, how do they do death, how do they celebrate birth, how do they experience all these various things, and the particular impacts of historical events on their culture. (Tamasese & Waldegrave, 2003, p. 137, as cited in Addy, 2008, p. 18)

Self-reflective questioning may encourage practitioners to develop a "respectful curiosity and joint process of enquiry that is less likely to privilege one culture over another" (Akamatsu, 2002, p. 51). A narrative question that I have adapted from Akamatsu is "How has being a Pākehā male with blood lines from Ireland and Norfolk Island shaped me as a counsellor?" The short answer is: significantly.

A few years ago my wife and I were travelling in Ireland. As we drove around the country I found that I had a strong connection to the land and to the Guinness. One experience that stands out vividly was that when we arrived at the Giant's Causeway in Northern Ireland I felt as if I had been there before, even though it was my first visit. As I stood on the causeway, memories of my poppa and his family flooded my mind and entered into the present with me. I went and grabbed some flowers and did an impromptu remembrance service for my poppa, throwing the flowers into the sea and saying a prayer. My wife recorded this,

and on our return to New Zealand I showed it to my gran, Poppa's wife. Gran and I were in tears as we shared the moment together, reconnecting with the memories of my poppa who had gone before us, and the way he continues to guide us in the present by the way he lived, how he treated us, and his care for others. Similarly, when I reflect on my connection to Norfolk Island, themes of adventure, resilience, and the Pacific way of life provide insights into my view of myself. Firstly, my gran has lovely dark skin due to her Tahitian blood. Consequently, she suffered from racism growing up. Hearing these stories has given me a heart for speaking up against injustices toward people, especially when based on colour. I also see her resilience, her love of family, the need for adventure, and a natural respect for Pacific cultures as values and principles that I live my life by now. As Lee (2006) maintains, "knowledge of oneself in relation to cultural heritage can produce a strong identification with one's people, and helps to bring a deeper feeling of belonging and meaning in life" (as cited in Addy, 2008, p. 18). Understanding where I come from has been, and continues to be, a key factor in being able to form effective therapeutic relationships with Māori tamariki as a counsellor.

Concluding thoughts

We return then to the question at the start of this essay: *tumeke bro?* or too much bro?

Is the space between the Māori tamariki I work with and myself too big to bridge? The answer lies in the relationship and that answer is no. The space between us can be the space that invites each of us toward the other when Māori worldviews, beliefs and ways of being are respected, valued and embraced, and when I know who I am—a Pākehā New Zealander who is proud of my blood lines from

Ireland and Norfolk Island—and how this affects the way I relate to others different from me.

Some personal implications for professional development and further research

Marae experience—in light of this reflection I look forward to spending a night on a marae. Reading about the pōwhiri and how it can assist me in negotiating relationships is one thing; experiencing it in the context of a marae is another.

Learning te reo Māori—although the counselling sessions with my tamariki clients are in English, integrating Māori terms and images more regularly and intentionally could deepen the possibilities of relationship building through modelling a respect for the language and culture. I am not sure whether I can really say I genuinely respect Māori culture without making an effort to learn the language.

Treaty obligations and social justice—Kedell (2007) states that the Treaty of Waitangi provides a constitutional imperative for Māori values and concepts to be included within legislative frameworks. In what way can I advocate publicly for the rights of Māori tamariki and their whānau when this process seems to be ignored or overlooked? I need to reflect more on the ways in which the Treaty of Waitangi and NZAC's commitment to partnership are expressed through my work as a counsellor with my clients and what I advocate for publicly on a national political level (Crocket, 2009; Te Wiata, Crocket, Woolf, & Mika, 2011).

Collaborative supervision—a possibility is to find a Māori advisor to spend time with who can join me in the process of careful reflection and support. Reading articles is one

thing; time together talking, listening, thinking, questioning, learning, and laughing person-to-person is another.

Effective resources for evaluating counselling effectiveness designed in collaboration with Māori tamariki for Māori tamariki—

Houkamau and Sibley (2010) aimed to create a culturally appropriate multidimensional model of Māori identity and cultural engagement as a therapeutic tool, because of the need they saw for "more detailed empirical research and theory on Māori identity" (p. 23). Drury's (2007a) Kaupapa **Outcome Rating Scale**, which monitors client progress and the alliance from the view of the client, is another tool that has proven successful. Further research and collaboration with Māori tamariki on adapting these for use with Māori children could be of value. Similarly, the development of session outcome scales and tools that are designed by Māori young people based on their understanding of the counselling process is worth exploring. This is a conversation I am starting with the tamariki I see at present.

After all, who is the counselling for? It is not for us. And shouldn't our clients have a sense of control over what their therapeutic pathway might look like? I for one say yes, and so do the tamariki I ask when they are given a voice.

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In this section we feature papers based on the keynote conference presenters Professor Pat Dudgeon, Dr Erana Cooper and Dr Alan Fruzzetti who presented at the joint NZPsS/ NZCCP conference in April this year. We also present papers on smoking cessation, research into the success of Māori achievers, the Psychologist Board's accreditation of training programmes and students' of clinical psychology theses abstracts.

Indigenous Australian Mental Health and Racism: There Could be Cathedrals of the Spirit as Well as Stone

Pat Dudgeon



Professor Pat Dudgeon is an Indigenous Australian Psychologist from Bardi people of the Kimberley. She is known for her role in higher education and in Indigenous Psychology. She was appointed as Head of the Centre of Aboriginal Studies at Curtin University in 1990. Pat was the first Indigenous convenor of the Australian Psychological Society Interest Group, Aboriginal Issues, Aboriginal People and Psychology. She is currently the founding chair of the Australian Indigenous Psychologists' Association auspiced by the Australian Psychological Society.

Abstract

In 1977, Koori activist and scholar, Kevin Gilbert wrote about the impact of colonisation upon Australian Indigenous peoples:

[Aboriginal and Torres Strait Islander people] were hit by the full blight of an alien way of thinking. They were hit by the intolerance and uncomprehending barbarism of a people intent only on progress in material terms, a people who never credited that there could be cathedrals of the spirit as well as stone. (1977, pp.2-3)

This paper critically examines the role of psychology in colonisation and where the discipline has come over the last three decades of unprecedented social and political change. An overview of Indigenous mental health is provided with a focus on the social determinants of health, particularly racism. Indigenous Australians face forms of individual, institutionalised and cultural racism every day. This paper comes from a position that research and practice in psychology has historically perpetuated inequities and racism in health and mental health. However, our discipline can be part of the solutions in the future.

Considerable changes are required to bring about equity in the way that health and mental health care is provided for Indigenous Australians. Some changes can be immediate such as the provision of quality cultural competence training with the mental health workforce. This presentation will overview other changes, including paradigms shifts that auger well for inclusivity of the discipline.

Introduction

Indigenous Australia is made up of two cultural groups; mainland Aboriginal people and Torres Strait Islander people. This paper uses the term 'Indigenous', unless referring to

mainland Aboriginal people.

Any discussion of the current mental health of Indigenous Australian people requires an understanding of its broader historical and cultural context. The history of colonisation and the subsequent devastation of Indigenous Australians, their resilience and their struggle to claim equality and cultural recognition shape circumstances today.

Major themes addressed in this paper include: the demographic, historical and cultural context of Indigenous Australia; Indigenous mental health as a product of that context; and more recent directions in Indigenous mental health.

Colonisation in Australia meant the loss of lands, languages, social systems and basic human rights and freedom.

Overall, Indigenous people make up 2.5 per cent of the total Australian population. The Australian Bureau of Statistics estimated that in 2006 there were 517,200 Aboriginal and Torres Strait Islander people living in Australia. Of these, it was estimated that:

- 463,900 (90 per cent) were of Aboriginal origin;
- 33,100 (6 per cent) were of Torres Strait Islander origin only; and
- 20,200 (4 per cent) were of both Aboriginal and Torres Strait Islander origin (Australian Bureau of Statistics, 2006).

Most Indigenous people live in major cities and while the majority live in urban settings, the Indigenous population is much more widely dispersed across the country than the non-Indigenous population. Additionally, Aboriginal people comprise a much higher proportion of the population in more remote areas and Northern Australia.

Aboriginal Cultural History

Aboriginal people have been in Australia for between 50,000 to 120,000 years, with approximately 300,000 Aboriginal people living in Australia when the British arrived in 1788. During colonisation it is estimated that the numbers declined to around 75,000.

Aboriginal Australians were hunter-gatherers who lived in small groups. Membership within each family or language group was based on birthright, shared language, and cultural obligations and responsibilities. Complex and sophisticated kinship systems placed each person in relationship to every other person in the groups and determined the behaviour of an individual to each person. (Berndt & Berndt, 1992).

According to Aboriginal beliefs, the physical environment of each local area was created and shaped by the actions of spiritual ancestors who traveled across the landscape. Helen Milroy, the only Aboriginal psychiatrist in the country, speaks of the importance of land as part of the Dreaming:

We are part of the Dreaming. We have been in the Dreaming for a long time before we are born on this earth and we will return to this vast landscape at the end of our days. It provides for us during our time on earth, a place to heal, to restore purpose and hope, and to continue our destiny. (Human Rights and Equal Opportunity Commission 2008, p. 414)

Colonisation: Resistance and Adaptation

European settlement brought introduced diseases, different social practices and beliefs. It also brought policies of extermination and massacre, protection and assimilation. Colonisation in Australia meant the

loss of lands, languages, social systems and basic human rights and freedom.

European settlement moved from Botany Bay outwards as settlers claimed land. The pastoral industry escalated the expansion, bringing increases in British immigrants. Broome (1994) calls the rapidly moving frontier of the mid-1800s as the most 'fantastic land grab, never again to be equaled' (p.37).

As their lands became increasingly occupied, Aboriginal people gravitated towards European settlements as their own food supplies were disrupted and they sought to access the convenience of European foods, tobacco and implements. Extremely high death rates and low birth rates led to their population decline to the estimated 75,000 at the turn of the twentieth century. Aboriginal people were perceived by the dominant society as hopeless remnants, clinging to what was left of their cultures and merely surviving. While there are many examples of Aboriginal groups across the country successfully adapting to colonization, Aboriginal people were then subjected to government policies that attempted over time to displace, 'protect', disperse, convert and eventually assimilate them.

Oppressive Legislation

At Federation, Australian states and territories had control and responsibility for Indigenous Australians. Each State of the newly formed Federation framed and enacted suites of legislations and policies that were punitive and restrictive towards Indigenous peoples. The effects were a form of cultural genocide of Indigenous Australians, through the loss of language, family dispersion and the cessation of cultural practices.

History demonstrates how racist beliefs became law. Aboriginal people were believed to be less than human,

and legislation was used to control them and confine them away from 'the public'. The Western Australian Aborigines Act 1905, for example, has special connotations today because of its gross erosion of rights, resulting in forcible removal of children and imprisonment of Aboriginal people onto reserves of servitude and despair. 1905 marked the start of a period of formidable surveillance and oppression of Aboriginal people. The Aborigines Act 1905 was not a protection for Aboriginal peoples, but an instrument of ruthless control. Very few Aboriginal people escaped the direct and indirect effects of the legislation that controlled and governed their lives.

It should be noted that Indigenous people and white supporters have continued to resist and struggle for justice since colonisation. The movement for Indigenous rights began in the 1920s, with the establishment

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of Aboriginal political organisations, in particular the Australian Aborigines League led by William Cooper and the Aborigines Protection Association with William Ferguson (Bullimore, 2001). Over time, various Indigenous political and support groups were established across the country.

The 1967 Commonwealth Referendum

In Australia, the 1967 Commonwealth Referendum symbolises the granting of full citizenship rights to Australian Aboriginal peoples. The 1960s and 1970s saw significant achievements that have now become historical

moments in the struggle for Aboriginal rights. These include the establishment of the Aboriginal Tent Embassy in Canberra, the creation of the Aboriginal flag by Harold Thomas in 1971, and land rights legislation. The trauma that Aboriginal people have suffered through colonisation, past policies and ongoing social disadvantage and racism is seen in contemporary situations. Kelvin Gilbert, a Koori academic, summarised the situation of Indigenous people as early as 1977.

[T]hey were hit by the full blight of an alien way of thinking. They were hit by the intolerance and uncomprehending barbarism of a people intent only on progress in material terms, a people who never credited that there could be cathedrals of the spirit as well as stone. Their view of Aborigines as the most miserable people on earth was seared into Aboriginal thinking because they now controlled the provisions that allowed blacks to continue to exist at all. Independence from them was not possible... It is my thesis that Aboriginal Australia underwent a rape of the soul so profound that the blight continues in the minds of most blacks today. It is this psychological blight, more than anything else that causes the conditions that we see on the reserves and missions. And it is repeated down the generations. (Gilbert, 1977, pp. 2-3).

Despite the reclamation of Indigenous culture, the traumas suffered during the process of colonisation, the loss and disruption of cultural traditions and loss of land still affects Aboriginal people today.

Health and Social Indicators

Where are we now? Not in a good place to say the least. Our statistics are appalling. We know things are bad but the statistics confirm our

perceptions. The national *Overcoming Indigenous Disadvantage Report: Key Indicators 2005/2007/2009 Reports* (SCRGSP, 2005, 2007 & 2009) provides a useful statistical database and shows that Indigenous people are the most disadvantaged group in Australia around key indicators such as: life expectancy; infant mortality; suicide death and self-harm rates; homicide death rates; especially involving alcohol; hospitalisation related to assault and alcohol abuse; and incarceration rates.

Despite the reclamation of Indigenous culture, the traumas suffered during the process of colonisation, the loss and disruption of cultural traditions and loss of land still affects Aboriginal people today.

In mental health specifically, the statistics are appalling.

- In 2003-04 Aboriginal and Torres Strait Islander people were twice as likely to be hospitalised for mental health and behavioural disorders than other Australians.
- Hospitalisation rates for intentional self-harm may also be indicative of mental illness and distress. In 2005-06, Indigenous Australians were **three times** more likely to be hospitalised for intentional self-harm than other Australians.
- Deaths from intentional self-harm were much higher for Indigenous people than for non-Indigenous people in 2003-2007, particularly for males.
- Additionally, intentional self-harm accounted for a higher proportion of causes of death among Indigenous people than non-Indigenous people in each jurisdiction.

While Torres Strait Islander people have their own distinctive culture, they share many of the same disadvantages as Aboriginal people (Australian Bureau of Statistics 2006).

This litany of impoverishment and disadvantage in an otherwise wealthy nation is shameful. The situation has many causes and no easy solutions, but it is clear that decades of colonial exploitation and a prolonged systematic attempt to destroy Indigenous people and culture lie at the core of the causes.

Despite current campaigns, government policies and attempts at closing the gap on Indigenous health inequalities, as noted in the Overcoming Indigenous Disadvantage Report (SCRGSP 2009), racism at individual and institutional levels continues to reproduce the impoverishment and disadvantage experienced by most Indigenous Australians.

Racism

According to the Human Rights and Equal Opportunity Commission:

There are no universally accepted definitions of racism, racial discrimination, xenophobia and related intolerance. Racism exists in many different forms. Generally, racism is a set of beliefs, often complex, that asserts the natural superiority of one group over another, and which is often used to justify differential treatment and social positions. This may occur at the individual level, but often occurs at a broader systemic or institutional level. (HREOC website)

Racism is not a simple concept; it is complex and historical. It is a significant issue and it is only recently that we have again put it on the table to look at ways we can bring about a society that owns its racism and that is open to begin to deal with it. In

owning racism we can truly start the journey to become culturally sensitive and culturally competent. Personally, I believe efforts to become culturally competent are one of the strategies against racism. Professionally, I believe our professions of health and mental health (including government departments) are not culturally competent and are racist.

James Jones (1997), an African American psychologist, proposed that contemporary racism should be considered at three different levels - individual, institutional and cultural. These are distinguished by the intersections of psychological, behavioural, institutional, structural and cultural dynamics in the processes of racialised beliefs and practices.

In owning racism we can truly start the journey to become culturally sensitive and culturally competent. Personally, I believe efforts to become culturally competent are one of the strategies against racism.

Individual Racism

According to Jones, a racist individual is:

... one who considers that black people as a group (or other human groups defined by essential racial characteristics) are inferior to whites because of physical (i.e., genotypical and phenotypical) traits. He or she further believes that these physical traits are determinants of social behaviour and of moral or intellectual qualities, and ultimately presumes that this inferiority is a legitimate basis for that group's inferior social treatment. An important consideration is that all judgments of superiority are based on the corresponding traits of white people as norms of comparison. (Jones, 1997, p. 417)

Often, people think that individual

racism must be overt and blatant; that if it's not obvious then it's not racism. If only that were the case! Individual racism is more often than not subtle and covert, dressed in a veneer of tolerance and acceptance, but no less invidious in its consequences. Subtle racism is much harder to change, as it is rarely recognised as racism, by the perpetrator and/or by the wider community.

Institutionalised Racism

While individual people are, rightly, seen as the agents of racism, it is important to appreciate how racism operates at a cultural and an institutional level. Institutional racism refers more specifically to the practices and structures of a society's institutions:

... those established laws, customs, and practices, which systematically reflect and produce racial inequities in society. If racist consequences accrue to institutional laws, customs, or practices, the institution is racist whether or not the individuals maintaining those practices have racist intentions. Institutional racism can be either overt or covert ... and either intentional or unintentional. (Jones, 1997, p. 438)

An institution can engage in racist practices without any of its members being individually racist. This is an important point to comprehend if we are to understand the damaging health and educational outcomes affecting Indigenous people. Low life expectancy, poor health overall, the high rates of unemployment, lower average income, low education and high rates of arrest and imprisonment are indicators of the consequences of entrenched institutionalised racism.

Cultural Racism

Culture is a part of the atmosphere of a society; a part of the tacit, assumed

way of doing things and comprised of the ideas, values, beliefs and shared understandings that together allow members of a culture to interact with one another. Accordingly, cultural racism:

... comprises the cumulative effects of a racialised worldview, based on belief in essential racial differences that favour the dominant racial group over others. These effects are suffused throughout the culture via institutional structures, ideological beliefs, and personal everyday actions of people in the culture, and these effects are passed on from generation to generation. (Jones, 1997, p. 472)

The three levels of racism – individual, institutional and cultural – interact with each other. Most Indigenous persons, in Australia and in New Zealand can recount stories of racism they have suffered at all these three levels.

Professionally, we constantly deal with racism in our discipline. Clinton Schultz, an Aboriginal psychologist, undertook a survey of 15 Indigenous psychologists and found that 11 of them had been confronted with significant racism either in their studies or in their work places; such that they had to leave. I myself mentored two Aboriginal women psychologists. One was actively undermined in her employment in a workforce selection company where she was responsible for assessments. She tried unsuccessfully to introduce a cultural section into assessments for Aboriginal clients which was not accepted. As a consequence, her professional integrity was continually undermined regarding her assessments. This experience of racism was very deliberate. The other psychologist just started to feel alienated and wanted her work place to undertake cultural competence training (as soon as I hear another Aboriginal person saying that,

I sense that they are feeling alienated and culturally unsafe). Her workplace was not deliberately racist, but it did not make provision to create a safe place for her. Once she identified how she felt it was too late, her oppression was entrenched in that environment. Both left eventually their employment.

These are two cases I know of, and I wonder how many other Indigenous psychologists have suffered racism in silence, who may have internalised this and felt that they personally were somehow lacking rather than seeing it as the forces of individual, institutionalised and cultural racism. The impact of racism on its victims and the danger that victims believe this oppression is justified or deserved in some way is my greatest concern.

Times have changed and our discipline has changed. The groundswell of what we have called the Indigenous mental health movement was, in a sense, part of a greater positive social change that happened for Indigenous Australia in the late 1980s, early 1990s.

Often we remain silent and don't share our experiences of racism because sometimes stories are unspeakable and threaten the core of our dignity. When I wrote my doctorate and described my grandmother's life and times, I outlined how she never spoke about the considerable oppressions she faced. I concluded that perhaps it was impossible to speak the unspeakable and perhaps she thought speaking it would make others think that she was somehow deserving of the demeaning treatment meted out to her across her life. As Aboriginal academic, Jackie Huggins wrote,

My mother does not want to talk even to me about the kinds of bitter treatment she experienced. What stops her from speaking is the same

thing that stops other people speaking about the profound suffering they have experienced. The oppression and pain can be so fierce as to make people mute. They carry this experience inside themselves.... Guilt and shame are manifest in women who have suffered this and there is a self-blaming that makes them see their situations as their fault or the fault of their race (1994, p36).

Jones' (1997) conclusions about the impacts of racism are relevant to Indigenous Australian People. He states that firstly, racism is a lived experience; it is real and happens in many ways. Secondly, racism not only hurts at the time it happens, but has a cumulative effect. These become part of the narrative of the community in an 'us and them' perspective. Racism at different levels might be seen as a natural part of life. Thirdly, repeated experiences of racism affect a person's behaviour and understanding of life; one's life expectations, perceptions of oneself and ones' groups and the dominant group and many ways of coping with racism contribute to the psychological reality of people of colour. Living with racism can become a central and defining element in the psychology of marginalised and/or people of colour.

In many ways, life is a struggle for people of colour. Even for those who have 'made it' and have overcome obstacles to achieve a meaningful life, different forms of racism need to be confronted; it is inescapable.

Changes in Mental Health and Indigenous People

What does all this mean to our discipline of psychology?

Psychologists belong to a profession that has historically been conservative and identified with the dominant Anglo-based and Western European cultural traditions of Australia. Like

other institutions, psychology has a history of excluding those from different cultures. In fact some would say they been complicit in the disenfranchisement of the marginalised and that they need to examine their role within the social and political structures and systems that give rise to, and perpetuate, racism.

There is a group of us who have been working in the area of Indigenous mental health for many years. When we initially came together as a group, there was little attention to Indigenous issues in Australian psychology. In 1991 when we set up the *APS Interest Group Aboriginal People Issues and Psychology*, imperatives such as social justice and self-determination were quite unusual discourses in psychology. Since the formation of the group, when we were always peripheral, we are now a strong part of the Australian Psychological Society (APS).

The 1995 APS Annual Conference in Perth Western Australia attracted an unprecedented Indigenous presence. For the first time there was an Aboriginal welcome to the country and the first ever Indigenous keynote presentation. Rob Riley, one of our most outstanding Aboriginal statesmen and social justice activists and was the first ever Indigenous keynote at an APS Annual conference. He was part of the stolen generations and as well as influencing the development of native title agreements he instigated the *Bringing Them Home* Reports. Rob took his life less than a year afterwards in 1996. The unresolved grief of his personal experiences and the never-ending challenges in the struggle for social justice wore him down.

I am proud that Rob Riley delivered our first Indigenous keynote. I am ashamed of our discipline that the space was so hard to win. I am resentful in retrospect that this keynote took place on the side of the main

program; it was not well attended and the senior people of our profession did not bother to attend. I am proud that although he was suffering at the time from acute stress, emotional distress and fatigue, Rob prepared and delivered an important, historical and now widely demanded paper, hoping that in some way it would make a difference. He charged us, psychology, with this responsibility:

How many psychologists have an understanding of Aboriginal people? How many of you ... have an understanding of Aboriginal culture, history and contemporary issues. For many of you, this work is crucial given the social conditions and your work environment in such places as prisons and the welfare sector and where there are large numbers of Aboriginal clients. It is your responsibility to seek that knowledge and understanding now, and to ensure that it is available for future generations of psychologists, in psychological training and education programs. (Riley, 1997, p. 15-16)

Have things really changed very much?

In the 1960s black psychiatrist, Frantz Fanon wrote:

... but the first encounter with the white man oppresses him with the whole weight of his blackness. (Fanon, p. 150)

Fanon believed that most mental illness and psychopathology in the oppressed was the product of a colonised situation, that is, that black people's neuroses stemmed from contact with the white world, with racism, and further that the institutions for mental health have only sought to 'cure' the native so he will accept being part of the social background of the colonial type:

Because it is a systematic negation of the other person and a furious

determination to deny the other person all attributes of humanity, colonialism forces the people it dominates to ask themselves the question constantly: "In reality, who am I?" (ibid)

Times have changed and our discipline has changed. The groundswell of what we have called the Indigenous mental health movement was, in a sense, part of a greater positive social change that happened for Indigenous Australia in the late 1980s, early 1990s.

One of the most significant events affecting Indigenous mental health was the *Ways Forward* Report (Swan & Raphael, 1995). And we were a part of this. We and other scholars in Indigenous mental health defined the historical period of this consultancy and report about Aboriginal and Torres Strait Islander mental health; a collaboration between non-Indigenous and Indigenous people in the field and a landmark event symbolising a different focus. Indigenous politically and culturally informed constructions of health and mental health began to emerge. Changes came about in perceptions of Indigenous mental health. Rather than the 'disease model' perspective there was a prioritising of wellness, holistic health, and culturally informed and appropriate approaches. For me, a most important element was that this process had included Aboriginal people in an unprecedented way.

These changes in perceptions toward Indigenous mental health were underpinned by key elements that included a philosophical approach of empowerment and self-determination in the provision of mental health services for Indigenous people. Services that worked with Indigenous people needed to ensure that mechanisms were in place for collaboration and direction from the client groups. Indigenous people

needed to be fully involved in any mental health activity for Indigenous people. Indigenous people themselves needed to direct the engagement, at all levels, whether this was an interaction between a psychologist and a client, or establishing services and developing policy.

To conclude with a personal vision ... If we don't change, if we don't own the racism in our country and professions, we cannot begin the change we need for a just, equal and well society that we can all share.

Mental Health and Emotional Social Wellbeing

Mental health problems and mental illness refers to 'the range of cognitive, emotional and behavioural disorders that interfere with the lives and productivity of people' (AHM 2003:5). A mental illness is a clinically diagnosable disorder that significantly interferes with an individual's cognitive, emotional or social abilities. Traditionally, the concept of mental health comes from an illness or clinical perspective and focuses more on the individual and their level of functioning in their environment.

An Australian Aboriginal view of mental health relies on a concept of social and emotional wellbeing which recognises that achieving optimal conditions for health and wellbeing requires a holistic and whole-of-life view of health that encompasses the social, emotional and cultural wellbeing of the whole community (SHRG 2004). A holistic view of health had been voiced by Aboriginal people in numerous reports in and was developed further in Swan and Raphael's *Ways Forward* (1995):

Aboriginal concepts of mental health are holistic and are defined as follows: Health does not just mean the physical

well-being of the individual but refers to the social, emotional and cultural well-being of the whole community. This is a whole of life view and includes the cyclical concept of life-death-life. Health care services should strive to achieve the state where every individual can achieve their full potential as human beings and thus bring about the total wellbeing of their communities. (1995, p20)

Social and emotional wellbeing problems cover a broad range of problems that can result from unresolved grief and loss, trauma and abuse, domestic violence, removal from family, substance misuse, family breakdown, cultural dislocation, racism and discrimination, and social disadvantage (SHRG 2004). As a concept encompassing this holistic view of health, social and emotional wellbeing also seeks to recognise Aboriginal and Torres Strait Islander people's particular experiences of grief and trauma through colonisation, separation from families and loss of land and culture.

Psychologists have gradually acknowledged this changed perspective. Many challenges remain and Indigenous researchers continue to call for appropriate inclusion of Indigenous people. Hunter a well-known psychiatrist wrote in 1997:

'Self Determination', 'quality of life', 'well being'... these are terms that have only recently entered the vocabulary of mental health professionals working in Indigenous settings. They are unfamiliar and handled with uncertainty and at times temerity. But they are also unavoidable. (Hunter, 1997, p. 6)

Conclusion

This paper has located Australian Indigenous mental health within its historical and cultural context and background of colonisation and

racism. The paper has argued for a broader approach to Indigenous mental health that recognises a social and emotional wellbeing model rather than a more clinically based one. The paper has highlighted and applauded significant changes occurring in the way Indigenous mental health is conceptualised; changes that it suggests auger well for the future.

To conclude with a personal vision ... If we don't change, if we don't own the racism in our country and professions, we cannot begin the change we need for a just, equal and well society that we can all share. The following message of hope is from Dr Joan Winch, a Nyoongar Elder:

So the struggle will continue, but we will not be alone, other Australians will be by our side, and together we will make a difference.

The most profound change has to happen in the hearts of those who wish to help. I believe that we can walk into the future together and build a country where cultural diversity is respected and celebrated, where the future for our children can be very different and positive from the past of our parents and grandparents. (Professor Joan Winch, Nyoongar Elder, The Last Word, 2000)

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Processes of Change in Dialectical Behavior Therapy

Alan E. Fruzzetti and Julie M. Skutch



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Dialectical Behavior Therapy (DBT) is a comprehensive, multi-modal treatment developed for complex, multiply-disordered clients with pervasive problems in emotion regulation (Linehan, 1993a; 1993b). DBT conceptualizes suicide attempts, self-harm, and other out-of-control behaviors as attempted solutions (albeit problematic ones) to severe emotion dysregulation, and targets these problems using a combination of both acceptance- and change-oriented strategies and interventions, helping patients learn a wide range of skills related to self-control, awareness, emotion regulation and good relationships.

Originally developed for chronically suicidal and self-harming women, DBT more recently has been applied successfully to other problems related to emotion dysregulation (eating disorders, substance use disorders, severe interpersonal problems, and so on), and has been successfully implemented in outpatient, inpatient, residential, day-treatment, emergency, and forensic

settings, with both adolescents and adults. DBT is the standard of care for Borderline Personality Disorder (BPD), which is considered the prototype of emotion dysregulation disorders, with considerable data to support its use with these populations. Both randomized control trial data and other studies have shown DBT to produce significant reductions in suicidal ideation, non-suicidal self-injurious behavior, depression, substance use, eating disordered behaviors, anger, and so on, as well as improved relationships and overall life functioning, with gains largely maintained at follow-up (cf. Feigenbaum, 2006; Robins & Chapman, 2007; Koerner & Dimeff, 2000 for reviews). More recently, DBT has been extended to treat clients with BPD and comorbid PTSD with promising results (Harned, Korslund, Foa, & Linehan, 2012), eating disorders (Chen, et al., 2009), as well as women victims of domestic violence (Iverson, Shenk, &

Fruzzetti, 2009), and a variety of family problems related to BPD (e.g., Hoffman, Fruzzetti, & Buteau, 2007).

Despite the success of DBT compared with other treatments so far, DBT has far from perfect outcomes, and so it is important to focus on improving DBT. In order to refine existing effective treatments we must first understand the effective components and processes of these treatments.

Dialectical Behavior Therapy (DBT) is a comprehensive, multi-modal treatment developed for complex, multiply-disordered clients with pervasive problems in emotion regulation

Thus, it is essential to understand what aspects of DBT might be primarily responsible for its successes. Future psychotherapy research will focus increasingly on understanding these factors, and will go well beyond simple head-to-head treatment comparisons. Thus, in this paper we will explore key structures, strategies and procedures in DBT that may be central to good outcomes. We will highlight specifically those aspects of DBT that are both important in DBT and not often central in other treatments, recognizing that other, more common aspects of treatment likely also play a role in successful outcomes.

Commitment Strategies

One of the earliest and most robust findings is the consistently lower dropout rate of clients in DBT compared to clients in other treatments (e.g., Gutteling, Montagne, Nijs, & van den Bosch, in press; Linehan et al, 1991; 1993; 2006). This is a particularly important outcome given the retention difficulties commonly reported with BPD clients and the often high stakes of clients dropping out (e.g., increased

suicide attempts, hospitalization, and greater costs), and may result from commitment strategies. Commitment to treatment includes commitment to treatment targets, structures, and processes, and is a crucial and specific part of DBT. Not only is there a great deal of effort expended in the “pre-treatment” phase of DBT to increase commitment, but these efforts are extended throughout treatment. These include strategies such as devil’s advocate, pros and cons, “foot in the door” and “door in the face” strategies, and analyses of prior treatment problems (cf. Linehan, 1993a). In DBT, treatment cannot begin or stay on track if the client (and therapist and team) is not firmly committed. It is understood that recommitment is needed repeatedly over time, as commitment waxes and wanes depending on circumstances. However, proceeding with a lack of commitment at any point is assumed to be counterproductive. Clients must commit to the treatment as a whole (i.e., structures, other requirements), its specific modes and procedures (i.e., skills training, individual therapy, skill coaching), and to implementing solutions that arise from chain analyses of problem behaviors. This ongoing attention to commitment is likely instrumental in keeping clients in treatment, and collaborating in treatment.

Dialectics

The philosophy of dialectics is both an underlying assumption and an active ingredient in DBT. Dialectics is employed as a way to understand both the behaviour change process and as a natural process of argumentation or discussion (e.g., between therapist and client, among team members), in particular about understanding behaviour. Traditionally, dialectics posits that when we try to understand some phenomenon (such as, “why did

this client self-harm on Friday?”), it is typical to start with a thesis (initial idea) which is quickly followed by its antithesis (typically something that was missing in the thesis), thus resulting in an apparent polarization. However, a synthesis may follow, which is the integration of these two polar opposites. Dialectics allows for flexibility in thought and a more expansive understanding of the truth in any given situation (Fruzzetti & Fruzzetti, 2009).

One of the earliest and most robust findings is the consistently lower dropout rate of clients in DBT compared to clients in other treatments

In the therapeutic dyad the thesis and antithesis can be the therapist’s and client’s often conflicting viewpoints of a situation. For example, perhaps a client believes that killing herself is the only way to escape intense emotional pain and her therapist believes that problem solving is the answer. Dialectics dictates that the therapist look for and highlight the validity in the client’s position (e.g., that she is in intense emotional pain, and cannot imagine it ending) and also pinpoint the salience of his or her own position for the client (that suicide is a very limited response, may not help) in order to come to some synthesis that allows a non-suicide solution to her misery (e.g., the therapist and client collaborating on skills to help alleviate the client’s misery without turning to suicide). Dialectics is everywhere in DBT, and may be considered a meta-process, and unique feature, of DBT. Dialectics most often manifests as a balance or synthesis of acceptance and change, although there are other dialectical tensions highlighted in the treatment and its underlying theory (Linehan, 1993a); Dialectics is included in skills (some focused on

acceptance, some more on change), in therapist communication style (at times accepting, warm, soothing and engaging, at other times pushing for change, being irreverent and/or confrontive), in deciding whether to intervene on behalf of clients (mostly consulting with client on how to be effective themselves, but sometimes intervening on their behalf). Dialectics help prevent the dyad from getting stymied and allow for competing perspectives to be valued (rather than searching for right and wrong), enabling therapy to move beyond impasses with both parties feeling understood and remaining committed and motivated.

Radical genuineness

Although not unique to DBT, an underlying attitude or position of radical genuineness on the part of the therapist is essential in DBT. Radical genuineness is conceptualized in part as a type of validation in which the therapist treats the client as a person, as an equal human being, which involves both real warmth and genuineness at times, and confrontation (not treating the client as fragile) at other times. It involves not seeing or treating the client as disordered per se and encompasses a belief in the client's innate strength and ability to achieve the changes needed for a life worth living (Linehan, 1997). This attitude fosters the therapeutic relationship and demonstrates deep respect for the person. Moreover, it emphasizes a sense of agency and competency in the client. Of course, radical genuineness occurs in the context of a treatment relationship in which roles (therapist and client) are also clear.

Multi-Component Structure

DBT is a systematic, multi-component *program* of treatment, not a traditional psychotherapy with a single mode of

delivery. This structure of treatment has important implications for efficacy well beyond simply increasing treatment time for clients. For example, in many studies the “dose” of treatment (how much treatment time is offered) is held constant between DBT and a comparison treatment, with DBT clients demonstrating superior outcomes (e.g., Linehan et al., 2006; Pistorello, Fruzzetti, Iverson, et al., 2012).

Dialectics most often manifests as a balance or synthesis of acceptance and change, although there are other dialectical tensions highlighted in the treatment and its underlying theory

In standard outpatient DBT there are five different functions of treatment that must be met, typically via multiple components or structures: 1) *Motivation of the client* (understanding dysfunctional behaviours, targeting them for change, with support and validation) occurs primarily in individual therapy; 2) Clients also attend *skills training*, typically in a group format; skills groups are not process oriented but rather psychoeducational in nature, with a focus on acquiring and strengthening skills from four skill modules (mindfulness, emotion regulation, distress tolerance, and interpersonal effectiveness; Linehan, 1993b); 3) *Generalization of skills* in clients' lives is facilitated both by planning and between-session skill coaching, often in the form of telephone consultation; 4) DBT also addresses both the *skills and motivation* of the therapists in the form of weekly consultation team meeting; and 5) At times, relationships in the client's social and family environments can impede progress; when this occurs, *family and other social interventions* may be provided for parents, partners, and other loved ones (cf. Fruzzetti, Hoffman, &

Santisteban, 2007).

Limited data show that DBT is most effective when offered comprehensively (all five functions), rather than when one or more of the components are withdrawn (e.g., Linehan et al., 1991). Moreover, the structure of DBT has an important impact on therapist factors. For example, the consultation team (somewhat unique to DBT), because of its dual focus on helping therapists improve their skills and providing support to them, may help promote job satisfaction and reduce burnout. In addition, the team provides ongoing feedback to increase or maintain fidelity to the treatment manual, which helps to buffer clients from inevitable therapist error and “drift” from adherent treatment. Improved outcomes, of course, also facilitate therapist satisfaction, and vice-versa.

Conceptualizing problems as skill deficits/teaching skills as solutions

In DBT, increased skills are the solutions to problems (Linehan, 2003). The treatment employs basic learning as one key process of change (skill acquisition, strengthening, and generalization) and empowers clients by helping them to achieve “skilful means” across all relevant contexts in their lives (treatment, intrapersonal, work, social and family environments).

This skill focus, although not entirely unique (e.g., behavior therapy shares this focus), is unusual in its application to emotion and emotion dysregulation. This skill focus has two key implications: 1) Client empowerment is a means to the goals of treatment (skilfulness leads to a more meaningful, satisfying life); and 2) Because clients are not “broken,” their problems simply require learning more skilful solutions. This helps reduce hopelessness and stigma among clients, therapists, and clients' families.

Emerging data point to skills as relevant and important to DBT's clinical effectiveness. For example, studies show that clients generally value and practice skills regularly (multiple times each day) outside of session (Lindenboim, Comtois, and

It involves not seeing or treating the client as disordered per se and encompasses a belief in the client's innate strength and ability to achieve the changes needed for a life worth living

Linehan, 2007; Miller et al., 2000). Skill use also results in reduced affect instability and relationship distress in an outpatient DBT sample (Stepp, Epler, Jahng, & Trull, 2008). In a randomized control trial, DBT skills training was superior to a standard group therapy condition for people with BPD in improving mood and affect instability (Soler, Pascual, Tiana, Cebria, Barrachina, Campins, et al., 2009), and the DBT skills group also had significantly lower dropout rates (34.5%) than standard group therapy (63.4% dropout).

More recently, skill use as a mechanism of change in DBT has been evaluated. Neacsiu, Rizvi, and Linehan (2010) found significant mediation effects of DBT skills on decreases in suicide attempts and depression and increases in control of anger. Skill learning during the treatment period partially mediated non-suicidal self injurious behavior. Although skill training alone is not as effective as comprehensive DBT with all functions met (e.g., Linehan et al. 1991), together these data do support the important role of learning new skills in attaining robust clinical outcomes.

Patient/client processes, or mediators of change

Examining skill use as a mediator of

outcome is one example of beginning to understand what changes in clients behaviors (in cognition, emotion regulation, overt actions, etc.) are essential to good outcomes. The DBT approach to understanding BPD and related disorders is organized around the role of emotion dysregulation (Fruzzetti et al., 2009; Linehan, 1993). DBT highlights the need for discrimination of emotions and emotional reactions, accurate identification and expression of emotion, and the ability to use acceptance and change strategies flexibly to manage or regulate emotion. In DBT there is no premium on tolerating or accepting emotions over changing them, if change is desired, possible, and the methods of modulation do not create other problems. Similarly, there is no premium on changing emotions, if acceptance is desired and does not create other difficulties.

If the primary dialectic in DBT is acceptance and change, it is reasonable to postulate that successful outcomes will depend on clients' abilities to increase their capacity for mindfulness, and acceptance, as well as emotion regulation and behavioral self-control. Additionally, the skill and flexibility to use both acceptance and change skills as needed is essential to build and enjoy a life worth living. Indeed, there is some empirical support for this. For example, in a recent study distress tolerance, emotion regulation and psychological flexibility were all significant mediators of primary outcomes, including reduced suicidality and depression, and improved interpersonal outcomes (Pistorello, Fruzzetti, Gallop, et al., 2011).

Of course, there may be many other key changes in clients' repertoires that are instrumental to good outcomes. Research on these processes of

change has only recently begun. For example, family functioning may be an important mediator or moderator of outcomes (Fruzzetti, Haynos, Papa, & Pistorello, 2012), and learning how to manage very specific emotions may be important. For example, in one study higher levels of shame measured in DBT sessions predicted more subsequent self-harm and shorter latency to self-harm in the subsequent week (Brown et al., 2009). This suggests that learning to reduce, accept or manage shame may be an important patient factor in successful outcomes. One way to begin to look at these kinds of variables is to examine closely what actually happens in the small moments in the therapist-client transactions in-session.

Therapeutic processes

Ultimately, what the therapist initiates and how he or she responds to the client define the psychotherapeutic process. Some of the things the therapist does are defined by the treatment per se (e.g., validation, challenging or confronting, listening, problem-solving, using specific protocols). However, the timing, intensity, and specificity of therapist responses may make a great deal of difference.

Given the centrality of emotion regulation in the theory and practice of DBT, it may be useful to consider how DBT therapists help clients regulate their emotion. These processes involve first establishing a clear target. Then, the therapist collaborates with the client to understand how (descriptively) the client went from a situation in which he or she was not dysregulated, to one in which he or she was dysregulated and engaged in some kind of dysfunctional behavior (the treatment target at this moment) to "escape" the aversive qualities of that dysregulation (e.g., self-

harm, drug use, restricting eating, aggression). Although functional or behavioral analysis is a mainstay of behavior therapy, the detail in which this “chain analysis” is conducted in DBT is rather unique, as is the relentless focus on emotion along the “chain” or pathway to the out-of-control behavior.

One of the key things that DBT therapists focus on is the distinction between primary and secondary emotions (cf. Fruzzetti, et al., 2009; Greenberg and Safran, 1987). Primary emotions are universal and adaptive. That is, they “make sense” rather universally if we understand the situation or trigger. For example, when we look forward to meeting a friend for a visit and the friend has the flu, we are disappointed (and maybe also concerned about the friend). In contrast, secondary emotions are emotional reactions to primary emotions, or result when a person is judgmental about the situation or himself or herself. For example, if the person started judging the friend by saying “he’s not a good friend, he’s a jerk for cancelling our plans” then the person would feel angry. In DBT, primary emotions are generally not dysregulated, in part because they “fit” the situation, and therefore other people can easily validate primary emotions. However, they can be painful, and it is common to jump to secondary emotions. Secondary emotions may not be dysregulated, but are at much greater risk for dysregulation.

DBT therapists are likely to pay more attention to the distinction between primary and secondary emotions than many other therapists because of the premium put on emotion dysregulation as the core problem. Research that explores what DBT therapists do and when (i.e., in response to what client behaviors),

especially when it is different from what other kinds of therapists do, can help us understand what therapeutic processes in DBT are unique and also important.

For example, the consultation team (somewhat unique to DBT), because of its dual focus on helping therapists improve their skills and providing support to them, may help promote job satisfaction and reduce burnout.

In one recent study (Fruzzetti, Pistorello, & Erikson, 2012), DBT therapists and psychodynamic therapists both were observed to validate at about the same rate. However, DBT were observed to more fully validate (“that makes sense” or “anyone would feel that way in that situation”) primary emotions than were psychodynamic therapists, who were more likely simply to acknowledge primary emotions (“so, you felt sad...then what?”). Similarly, DBT therapists were more likely to minimally validate and then immediately block secondary emotions and redirect to primary ones, whereas psychodynamic therapists were more likely simply to validate secondary emotions. Given that outcomes favored DBT (Pistorello et al., 2012), and that these therapeutic behaviors were related to outcomes, it seems likely that these kind of therapeutic processes are key processes of change, at least in part related to successful outcomes. Learning to refocus on primary emotions may be a key pathway toward successful emotion regulation, and in turn to good clinical outcomes.

Of course, much more research is needed to explore these, and many other, specific therapeutic processes to understand DBT, and to compare DBT processes to those in other treatments. Now that DBT has been

established as an effective treatment, more resources can be devoted to identifying and understanding exactly what the most important processes of change are in all DBT components. Hopefully, this will lead to further improvements in the treatment, and more successful outcomes for very distressed, multi-problem clients.

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Tōku reo, tōku ngākau: Learning the language of the heart.

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Dr Erana Cooper is a clinical psychologist and lecturer in Kaupapa Māori Psychology at The University of Auckland. Her experience spans the areas of academic, research and professional practice, and she is passionate about advancing Māori development and initiatives. Erana teaches a broad range of material related to Māori perspectives and methods in mental health, clinical

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In the profession of psychology in Aotearoa, there continues to be increasing attention paid to learning about “how to work with Māori”. But what does this really mean in practice? How do we best work with Māori, not only as practitioners, but also as colleagues and advocates for social justice and change? In this paper I hope to weave together ideas from the literature and experiences from the field in a way that will encourage psychologists to resist treating “standing together” as an academic exercise and instead explore the opportunities created by connecting.

When I first saw the 2012 conference title “Tūtahitanga: Standing together as one”, I wondered what was meant by this. While I believe there is positive intention behind the idea of being ‘as one’ or ‘standing as one’ in terms of being connected to each other and bound together by our greater humanity and the common purposes we may share, I think there simultaneously exists the peril of diminishing opportunities for understanding, acknowledging and being accepting of important differences between peoples in the pursuit of ‘one-ness’. For example, if we were truly one people here in Aotearoa NZ, everyone might understand completely if I was to present this paper all in Māori, perhaps? We may want to be ‘as one’ with others in terms of our ability to genuinely and meaningfully connect with them. However, if, for example, we can’t speak that other person’s language, the type of connection and understanding we seek can be more difficult to make. What we can do

however, in the absence of those certain points of connection (such as language), and in the interests of wanting to acknowledge and accept difference where it exists, is to speak to people's hearts – using our heart.

Heart and Mind / Art and Knowledge

Our profession, particularly that which is focused on the practice of psychology with others, is abound with literature about the importance of the therapeutic relationship as a function of successful therapeutic intervention (e.g., Lambert & Barley, 2001). We also know that it is often not merely the therapeutic relationship that is effective, but the many different skills and techniques we have learnt as psychologists; it is the application of knowledge and skills that can contribute to successful therapeutic outcomes. Alongside this is an increasing call to awareness about the influences of our own values, attitudes, beliefs, practices and worldviews on our practice as psychologists, as well as awareness of the influences that others' values, attitudes, beliefs, practices and worldviews have on us (Hays, 2008; Jun, 2010). Working with the heart and the mind is about the intersection of practising the 'art' of being a psychologist and the application of knowledge (Jun, 2010). In this sense, the art of psychology is related to how well we do things with our clients such as demonstrating respect, building rapport, showing empathy, developing trust, having compassion, accepting and valuing clients; while the application of knowledge is more related to the use of the therapeutic methods and techniques we have learnt and believe will be useful for our clients. When we're talking about our practice, this involves being present with both heart (art) and mind (knowledge) (Jun, 2010). I consider this to be the crux of

cultural competence, and this sets the foundation for the ideas that follow in this paper.

Know Yourself

One of the first things we can do in terms of meeting the challenging of working with 'heart and mind' with Māori is to come to know ourselves. Our own cultural identities such as our ethnicity, our gender, our age, our socioeconomic status (among others), and all the related values, beliefs, attitudes and practices we hold in relation to these, are hugely influential on us. We can build up awareness around this. We can ask questions such as "Who am I? (what are my various cultural identities?); "What do I value?"; "How did I come by these values?"; "How do these values show in the way I act, speak, dress or live my life?"; "How is my view of the world shaped by the experiences I have had?"; "What is my experience of privilege? Or oppression?"; "How does all of this influence my understanding of my clients?"; (Hays, 2008) "How does all of this influence my work with Māori clients?". Revisiting these questions is an on-going process, we can all continue to discover more about ourselves and how we are influenced in our practice. There are entire books dedicated to helping us do this. However, there is still very little written literature available which focuses specifically on how this might all relate to working with Māori. To account for this, the following is a case example of how relevant I think it is to know about ourselves, the influences on us, as well as the influences we may have on others.

Years ago I was working at a clinic when a referral arrived about a young Māori woman who needed to be seen rather urgently with concerns about low mood and relationship difficulties. She stated she didn't want to see a

Māori psychologist. All staff at the clinic were very busy, and a week passed. At this time, (Becky – not her real name) phoned again to say that she would take an appointment to see me. I was a little apprehensive about meeting Becky, knowing that she had originally not wanted to see me. I introduced myself and suggested we go into one of the clinic rooms. As we sat down, she gushed out "well, thank God you look like you do – that's a relief!" I figured (correctly) that she was probably referring to how fair I am – our whānau often joke about being 'undercover Māori' as we are all very fair, which brings with it some interesting experiences. I said to Becky "you were expecting someone who looked different to me?" She said "well, yes, when I was told I was going to see a Māori psychologist – I had an image of you coming out in a long dress, with your hair up and a moko on your chin, singing out 'Haere mai, haere mai haere mai' (a karanga) for me to come in with you"!!

...in the absence of those certain points of connection (such as language), and in the interests of wanting to acknowledge and accept difference where it exists, is to speak to people's hearts – using our heart.

We both burst out laughing. But it led to an interesting discussion about her upbringing (with her stating that despite identifying as Māori, "I wasn't bought up a hard-out Māori") and also her fears about expectations I might have of her as a Māori woman which she felt she wouldn't be able to fulfil (e.g., that she could speak te reo and that she would be knowledgeable about Māori cultural customs and behaviours). I didn't have these expectations, but she clearly

felt this might be an influence she might feel from me. However, she also had fears that I wouldn't understand the complexity of her whānau, her relationship with her partner (who also turned out to be Māori) and his whānau. It struck me, in many ways, how fundamentally Māori many of her experiences were even in the absence of explicit cultural markers such as being able to speak Māori or having a strong understanding of tikanga. Through many of our conversations wove this underlying theme of 'being Māori' (even when not explicitly stated so) and the influences this had on Becky over the course of her experiences in life.

I later found myself wondering about what her experience of therapy may have been like if she had seen someone who had more literally taken on board her expressed preference not to be seen by a Māori psychologist. How might a non-Māori psychologist have interpreted this? Would Becky's 'being Māori' have been put to one side? Or would those same conversations about her values, her beliefs, her hopes and desires – which I believed were so closely related to her experiences as a Māori woman – have still been able to occur? Would it have mattered if they did or they didn't?

These are the types of questions I think some of us might commonly face as practitioners. Engaging with Māori, as Māori, where this is clearly desired and expected can potentially be so much more straightforward than engaging with Māori who appear ambivalent about their identity as Māori. What is our role in this situation? Firstly, I believe we have to be aware of ourselves and the influences we may have on others. And also, that we do remain curious about others' identities and how they influence them, and us, when we encounter them. I believe cultural

identities and the influences they have on a person provide the context(s) for understanding that person. Often, the difficulties they encounter, that lead them to us as psychologists, develop within the broader framework of these contexts. Therefore, paying attention to identities can be really important.

While 'history is history', we can decide, as psychologists, to incorporate an understanding of historical trauma into our practice with Māori.

Be Informed About History

It is important to be informed about history when working with Māori. Even though it is great that most university programmes which lead to registration of psychologists nowadays incorporate cultural competence training that is related to Māori (such as needing to attend a Treaty Workshop, a series of seminars, or something similar), I think we can do more. To me, it is the way that we engage with history, and the depth to which we do this, which involves developing an understanding and analysis of the way history has influenced contemporary realities for Māori today, that is most important. There are many ways we can do this. We can read all kinds of different literature about NZ history. We can investigate and examine things happening all around us that reflect our history (for example, we could follow politics or representation of Māori in the media for a while). We can look far and wide for information about

history and its relevance for Māori and us all today. However, I think is most helpful to take the time to sit with what we learn, and ask ourselves what we really think and feel about what we are learning. This type of learning leads, almost inevitably, to getting to a place in which a different point of view can be seen. For example, learning about history in relation to te Tiriti o Waitangi/the Treaty of Waitangi, not only involves learning about the actual Treaty - what it means, how it came about, what the intentions were behind it and hopes invested in it, but also involves developing an understanding of how the impact of both historical and contemporary actions in relation to the Treaty result in the type of protest action we see annually, on Waitangi Day.

As a further example, when we learn about the history of colonisation in this country, which is inextricably linked to the Treaty, we encounter devastation and loss for Māori. These experiences can be described as historical trauma. Many authors today describe the effects of colonisation as profoundly negative and significantly harmful to Māori health and social, cultural and economic wellbeing (Balzer et al., 1997; Durie, 1998,



(taken by the author at Waitangi, Bay of Islands, 2012).

2001; Jackson, 1988; Lawson-Te Aho & Liu, 2010; Reid & Robson, 2007; Robson, Cormack & Cram, 2007). For example, the loss of land, language and access to cultural ways of being are all considered to be enduring adverse outcomes of colonising processes for Māori. Additionally, disadvantages which had their origins in colonisation appear to have stood the test of time. A number of authors argue that colonising processes carry through to today and continue to impact negatively on indigenous wellbeing through factors such as enduring discrimination, marginalisation and systemic and structural racism, which ultimately contribute to prevalent and persistent health and socioeconomic inequalities (Harris, 2006a, 2006b ; Jensen et al., 2006; Robson et al., 2007; Reid & Robson, 2007). Colonisation is becoming "... increasingly recognized as a fundamental underlying determinant of health" (McShane, Smylie & Adomako, 2009, p.19), and local indigenous authors such as Durie (2011), for example, suggest that effects of colonisation "... combined to marginalize successive generations" (p.28), and early effects such as economic disparity and lack of an effective political voice remain as a legacy of colonisation today.

This isn't something in our imagination; contemporary vulnerability is evident in many of the types of reports that we see today with regard to Māori (e.g., , on topics such as socioeconomic inequalities in mortality and over-representation of Māori in the criminal justice system (Ministry of Health & University of Otago, 2006; Policy, Strategy & Research Group, Department of Corrections, 2007).

Despite these contemporary examples, it is critical for us to consider how this state of being,

or how these experiences for many Māori, came about. We can ask the obvious question, "What part does our history as a nation play in this?" While 'history is history', we can decide, as psychologists, to incorporate an understanding of historical trauma into our practice with Māori. We might consider that there is the potential that the contemporary vulnerability presented by the Māori clients we see may be, perhaps even just partly, related to history and historical trauma. This is not to remove the task of Māori taking personal responsibility or being accountable, but to provide a framework or a context for psychologists to consider as a potential influence on Māori clients.

This means that even when we see Māori as individuals, we may literally be only seeing one Māori person in the room, but in fact we may actually be 'seeing' (impacting on) an entire Māori whānau.

For example, the doctoral research I carried out investigated 'what works in intervention in whānau violence?' and involved talking with whānau who had experienced difficulties with whānau violence. The stories of many of those whānau who participated clearly reflected those of vulnerable whānau who had led lives affected by generations of deprivation, disadvantage, disconnection, and dispossession, which in turn (to use our psychology language) had exposed them to a multitude of risk factors. In my opinion, their stories reflected both historical and contemporary trauma they had experienced (Cooper, 2012).

Understanding the influences of trauma on our clients can be helpful, not only for providing a framework for us from which to understand their difficulties – but also to enhance

our empathy towards them. The professional psychology literature tells us that understanding the role of trauma in clients' lives can increase our empathy towards them. This in turn has been shown to increase our confidence and comfort in our ability to help, and especially so in challenging situations (Greenwald et al., 2008). The message promoted many years ago by colleagues in our profession, about working "in the presence of history" (Awatere-Huata, 1993; Tamasese, 1993) remains a strong message worth repeating here today.

Honour a Māori Worldview

We can also honour a Māori worldview. To truly engage and connect well with Māori as clients, we must accept that there is a Māori worldview (although this will obviously vary a little in relation to the diversity among Māori), and we must act in a way that shows we do accept and value this. While it seems contrite to say it, time and time again over the past approximately 15 years or so, I have heard or seen examples of where this was clearly difficult for some psychologists.

In order to honour a Māori worldview, obviously we have to find out more about what that worldview is. The opportunities available to do this today are so much greater than they were even a decade ago. Aotearoa is awash with examples of te reo and the practices of tikanga, and many other things related to Māori worldview, in many different domains. Yet still there exists a struggle for some to really understand even the most fundamental aspects of what it is to 'be Māori'. For example, whānau, or the concept of the collective, is very important to many Māori. While understanding the importance of whānau is something that many

psychologists do, and is in fact, an ordinary practice for many— for some it is not, and it is a fact that Western orthodoxy which focuses on the primacy of the individual prevails in much of the training and professional practice of psychology in Aotearoa today.

the importance of, or even a broader understanding of, whānau is not incorporated by some psychologists into their practice. It can be easy for us to become attached to the frameworks that we develop and hold from our training, when these may invariably not match the frameworks that many

within a broader framework of action towards restoration of wellbeing.

Consider Restorative Practice

It is worth considering that our work is, or can actually be, about restorative practice. The discipline of clinical psychology, as we know, is concerned with the amalgamation of psychological research, theory and practice, and the application of this to a wide range of mental, emotional, developmental or behavioural difficulties across the lifespan of individuals and families. In this regard, the work of clinical psychologists is really about improving human welfare (American Psychological Association Society of Clinical Psychology (n.d.); New Zealand Psychologists Board, n.d.). The discipline of community psychology is also concerned with enhancing wellbeing, but it is much broader in its application. It is focused not only on individual and family health, but on promoting social justice, empowerment, and prevention of difficulties for all people, especially where there is historical or current oppression, marginalisation, or power differentials among groups. Acknowledgement of diversity is central and there is strong interest in the influences in the broad contexts within which human strengths and difficulties exist; this includes social, cultural, historical, geographic and economic contexts (American Psychological Association Society of Community Research and Action – Community Psychology, n.d.; Moane, 2003; Robertson & Masters-Awatere, 2007). While these are not completely full definitions of each discipline they do highlight some key points.

Also worth highlighting is the point that despite these being two quite distinct psychological disciplines in their nature, there is a degree of cross-over between the two, particularly

If we have Māori colleagues, or even if we don't, do we advocate for Māori in our services? In our training, in our academic curriculums, and professional development opportunities – do we advocate for Māori?

Despite the adverse impact of colonisation and its consequences, the value that many Māori place on being part of a collective has remained resilient. Therefore, psychologists working 'one-on-one' with Māori can benefit from remaining fully cognisant of the paramouncy of whānau for many Māori, and not be tempted into thinking they are working with 'isolated' individuals who are completely independent agents in their own lives. It may instead be helpful to regard Māori individuals as being part of a collective and therefore subject to the influences of that collective on their lives and behaviour, and subsequently that they may also benefit from connection with the support to be gained from that collective. Obviously whānau are diverse and not always the site of support or safety for Māori individuals and this should also be taken into account (Durie, 2001; Pihama et al., 2003). However, overall, an orientation to a view which situates Māori within a collective is helpful. This means that even when we see Māori as individuals, we may literally be only seeing one Māori person in the room, but in fact we may actually be 'seeing' (impacting on) an entire Māori whānau. While this all may seem so glaringly obvious, unfortunately there remain examples of situations in which

Māori hold. I also think that while we benefit from the support, knowledge and wisdom of colleagues such as Māori cultural advisors (that may support both us and Māori clients in our services), we also do not leave the task of honouring a Māori worldview solely to them. I believe that the challenge for us, as psychologists, is to be the ones to honour a Māori worldview.

It is important to acknowledge that adjusting our practice to fit different frameworks or worldview can feel difficult, and can involve a certain amount of risk. The balance between how we apply our heart (or our art) and our mind (or our knowledge) is so important. Sometimes we can feel like we're stepping out of line when we do these things. However, we may also like to consider, as psychologists, the risk that we expose others to, for example our Māori clients, when we aren't willing or able to adjust the way we think and the way we practice when it comes to working in the best way for them. Sometimes the costs, or the risks associated with that, are high. Our practice doesn't need to be a site of contest between our heart and mind. Rather we can blend these approaches in a way that will result in better outcomes for clients. One of the ways we can be encouraged to do this is to view our clinical work as existing

once we move out of the academic world and into the 'real world'. I wonder what would happen if we thought about these similarities a bit more, and imagined taking a unified community/clinical approach to our work? (although we wouldn't want to end up with 'Com-ical Psychology'!). We might well find that although the divisions exist which we create among ourselves by marking fences around each of our own areas; in fact many of us are doing very similar work or have very similar purposes to our work. Accordingly, it can be helpful, as Dohrenwend (1978) noted, in a very early analysis of these different 'camps' of psychology, that we remember the common ground that exists between community and clinical psychology. That is, that "clearly, we would all like to promote positive outcomes and prevent negative outcomes among individuals who are exposed to stressful life events" (p.6).

I would argue that when we think about our work with Māori, we think about it not only as an opportunity to be able to contribute to addressing stressful life events with individual Māori or Māori whānau sitting in the room with us as clients, but that we also see and take up opportunities to prevent, reduce, or address the conditions or factors which exist to create those stressful events or experiences for Māori where we can. This is the opportunity to engage in restorative practice. For example, do we care, as psychologists, about disparities and inequities faced by Māori? Might we support research activity or funding that would go towards addressing these? Might we use any political power we have in the various committees and other groups we belong to, to advocate for better health outcomes for Māori, for example? If we have Māori colleagues, or even if we don't, do we advocate

for Māori in our services? In our training, in our academic curriculums, and professional development opportunities – do we advocate for Māori? Do we become proficient in certain practices or approaches so that certain tasks don't always fall to our Māori colleagues? Do we advocate in a more general space in our everyday lives by addressing racism or discrimination against Māori 'head-on' when we encounter it? These are all things for us to think about, and to contemplate, as psychologists. I believe we are all in a unique position to do this in our profession. We are, overall, I believe quite well supported to do this by our professional bodies. We have a good chance at making things better, not only for Māori, but for us all.

Be Ready for the Future

This leads positively to the final point of this paper, which is that as part of our 'heart and mind' work, we can decide to be ready for the future. Our nation is continually changing, and as a result of this, our work with Māori is also likely to keep developing and changing. For example, we may hear a lot of talk about Māori who are disconnected or marginalised or disenfranchised in many ways, and that these can be contributing factors in their presentation to psychologists.

However, what about those Māori who are strongly connected to their culture and identity, who are 'first language' Māori speakers, and who so strongly exist within their Māori worldview? A lot of those young Māori who first went through Kohanga and Kura Kaupapa Māori – or total immersion Māori schooling – are now in their 20s or older, and may present to our adult and family services at any time, and in terms of younger Māori perhaps even earlier to our child and adolescent mental health services.

When I think about the majority of mainstream psychological services that I'm aware of, as a psychologist and as a Māori person, my heart aches a little for them. Who will be able to speak their language? There are few Māori psychologists available, let alone Māori speaking psychologists, so the chances of 'happening' upon one of them in one of those services is quite remote. I wonder, who will be able to at least speak to their heart?

... we need to come together with Māori. We need to talk to each other, we need to work together, and we need to walk together, if, in the end, we really want to 'Stand Together'.

Obviously learning the language of the heart isn't just about ticking boxes. We can't really say "Great! I've got awareness, got knowledge, got some skills – woohoo! I'm done!". Instead, we can be asking all the time, questions such as, "Do I know myself and what influences me?" Am I informed enough for my practice with Māori?" "Can I honour a Māori worldview?" "Would I consider restorative practice to be part of my work?" These are all important questions in our quest to work with Māori in a way that shifts us away from this just being an academic exercise, and instead moves us towards really connecting with Māori. Clearly, our journey towards cultural competence or our journey towards being able to really strike a balance between our heart (or our art) and our knowledge (or our mind), is a continual journey over time that will involve much perpetual searching and learning.

To do this, no doubt we need to come together with Māori. We need to talk to each other, we need to work together, and we need to walk together, if, in the end, we really

want to 'Stand Together'. I think this is an admirable goal, and one we can definitely achieve if we are willing to put our hearts into it. In the words of one of our esteemed tupuna, Sir James Henare, "Maha rawa wā tatou mahi te kore mahi tonu, tawhiti rawa to tatou haerenga, te kore haere tonu. We have done too much to not do more, we have come too far to not go further".

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Preview of NZPsS Professional Development events coming up in 2013

Translating the Principles of Mindfulness into Clinical Practice

A weekend retreat in Christchurch
15-17 February and in Auckland
8-10 March 2013.

Presenter: James Carmody PhD is an Associate Professor of Medicine at University of Massachusetts Medical School. He has been a therapist, an instructor in the UMass Mindfulness-Based Stress Reduction program, and Director of Research for the Center for Mindfulness.

An ecology of mind - a daughter's portrait of Gregory Bateson

Auckland - last week of February

Nora Bateson will show her movie and following this present a seminar on *How do Gregory Bateson's Ideas Resonate in Today's World*

Nora is the writer, director and producer of the award-winning documentary *An Ecology of Mind*, a portrait of her father Gregory Bateson's way of thinking.

For more information please contact the Professional Development Coordinator on pd@psychology.org.nz or check our website: www.psychology.org.nz

How Best to Support Someone Quitting Smoking

Karen Evison

Target Champion, Tobacco Control Programme, Ministry of Health

“It is now proved beyond doubt that smoking is one of the leading causes of statistics.” *Anon*

Unfortunately, the fact is that, one in five New Zealanders are represented in these statistics. Māori and Pacific people have even higher rates of smoking and these differences in smoking prevalence have a direct impact on the health inequalities seen in New Zealand. Similarly, tobacco use among people with mental health illness is higher than in the general population and it has been estimated in New Zealand that 33 % of cigarettes are consumed by people with mental health disorders^{1 2}. While smoking prevalence rates are slowly declining, there is still a long way to go to reach New Zealand’s goal of a Smokefree Aotearoa 2025.

Survey data tell us that four out of five smokers would not smoke if they had their life over again and three out of five have tried to quit in the last year³. More recent data suggests that people who smoke are making frequent quit attempts, at least once a year, on average⁴. Most of these quit

attempts will be undertaken without any support, but many of these people would benefit from assistance to quit. While we know that people are trying to stop, it seems that what they don’t know is how to best go about doing this. Addiction is often associated with guilt and shame, both of which can be disempowering.

Psychologists are particularly well placed to motivate people who smoke to quit, and support them in their journey to becoming smokefree. As part of the research to put this article together, we spoke to Dr Veronika Isler, who incorporates cognitive behavioural therapy (CBT) in her approaches with clients. This article represents her approach to helping smokers to quit.

Dr Isler believes teaching clients how to cope with the stress that their environmental factors, and their own appraisal of the world, creates, is a very important part of supporting people to overcome tobacco-dependence. In the absence of such skills, many people use smoking as their coping mechanism to deal with stressful situations or, alternately, see smoking as a reward during the tough times.

Not only can quitting smoking be beneficial for a person’s health, the self-esteem boost a person gets when they beat their addiction, which may have previously eluded them, gives them confidence in other areas of their life. People feel proud when they have freedom and are in control – especially when they’ve overcome something that they felt had previously mastered them.

Every hour that people go without
0443.2011.03685.x.

cigarettes will improve their health. Blood flow improves and the risk of sudden death from a heart attack is reduced. After five years, the risk of cancers of the mouth, throat and oesophagus is half that of a person who continues to smoke. After ten

Survey data tell us that four out of five smokers would not smoke if they had their life over again and three out of five have tried to quit in the last year

years, the risk of lung cancer is half that of a person who continues to smoke and after fifteen years the risk of heart attack is the same as that of someone who never smoked. The benefits can also be immediate with taste and smell improving within days of quitting and lungs working better, so exercise and other activities become more enjoyable. Additionally, the research also clearly indicates that there are direct links between quitting smoking and improved mental health and wellbeing⁵.

While most of the health benefits of quitting are well documented and smokers are generally well informed about the dangers and risks of the habit they are trying to kick, they tend to be less informed about the help and support that is available or the approaches and strategies that are most likely to lead to a successful quitting attempt. This is another aspect where health professionals play a crucial role.

Quitting smoking can be a daunting

⁵ Jonathan Campion, Ken Checinski, Jo Nurse and Ann McNeill, 2012. Advances in psychiatric treatment - Journal of continuing professional development. Smoking by people with mental illness and benefits of smoke-free mental health services

1 Lawn S, Pols R. 2005. Smoking bans in psychiatric inpatient settings? A review of the research. *Australian and New Zealand Journal of Psychiatry* 39(10):866-85

2 Tobias M, Templeton R, Collings S 2008, How much do mental disorders contribute to the New Zealand tobacco epidemic? Tobacco Control. Published online 31 July 2008. <http://tobaccocontrol.bmj.com/content/17/5/347>

3 2009 Tobacco Use Survey, Ministry of Health www.moh.govt.nz

4 Ref: Borland R, Partos TR, Yong HH, Cummings KM, Hyland A. How much unsuccessful quitting activity is going on among adult smokers? Data from the International Tobacco Control Four Country cohort survey. *Addiction*. 2012 Mar;107(3):673-82. doi: 10.1111/j.1360-

prospect and the options can be confusing. People need guidance through the process – both in terms of information and helping navigate the territory and what they can expect, but also in helping them reflect on their own desires and reasons and motivations for quitting.

Extending invitational questions, drawing on tools such as motivational interviewing and appreciative inquiry, helping people to challenge some of their limiting assumptions and identify their own drivers for change are excellent ways to support someone in their decision to quit. It must remain their choice, their decision, and their journey – in that way you are helping them regain the very things their addiction to tobacco has robbed them off. As psychologists, you are especially well-positioned to assist people in finding their own strength to quit and help discover what their previous barriers to quitting might have been.

As psychologist Dr Veronika Isler observes the challenge for most smokers is that smoking is often not the main problem in itself, but rather a coping mechanism for other difficult circumstances in their life or unhelpful thought patterns they may harbour. There are a number of maladaptive behaviours that they might engage in which pose difficulties in their life, and the scope of your role and expertise lends itself perfectly to working with them in reducing these behaviours.

Smoking is, in part, driven by underlying emotional factors and core beliefs, just as much as drinking, gambling or other addictions and obsessions or compulsions. Smoking needs to be addressed as a whole package of changing one's life for the better. The physiological reactions that often lead to anxiety and panic (and in the long-term, diminished overall health) need to be addressed first, in order to alleviate stress and allow

people to make changes in a more comfortable way.

In describing her approach, Dr Isler explains that she then addresses, and hopefully helps patients to change, the maladaptive coping behaviours that are a result of the patient's predispositions and antecedents. The intervention strategies include various approaches that are all aimed at changing a harmful behaviour into a useful one – such as changing aggressiveness into assertiveness and replacing smoking with another hobby or social or physical activity.

There are many individual reasons why quitting might not have worked for some people previously. Often the person does not really want to quit – the perceived rewards are still too great – and they will often voice this outwardly to perhaps appease their conscience or others around them.

As psychologists, you are especially well-positioned to assist people in finding their own strength to quit and help discover what their previous barriers to quitting might have been.

Dr Isler ensures that the client is aware that trying to get rid of a particular behaviour does not work in isolation and the underlying reasons about 'why' have to be addressed first. A few sessions may be required to find out about why they started, what keeps them smoking and what their rewards are. The individual elements of what a stressor is, how they think about it, how their body reacts to it and what do they do to try and solve the stress is very individual to each person.

Dr Isler's CBT framework involves motivational interviewing, mindfulness, harm reduction, behavioural, hypnotherapy and other elements that fit under the general CBT umbrella. Depending on the

culture or individual needs, certain elements are more prominent than others and the feedback of the client is always what guides the intervention.

Changing a habit requires the introduction of 'replacement rewards', the physiological cravings need to be addressed to avoid the preoccupation of the 'pain' and difficult times smokers may experience when quitting. It's also important to identify the underlying reasons why they started and what 'reward' they have looked for smoking to give them and then for them to consider whether that is what they seek and, if so, how else it might be attained. Failure often comes from trying to focus on the resulting behaviour, without giving correct attention to all the elements that lead to that behaviour and inhibit change.

Often a contributing factor to smokers wanting to quit will be the point at which they perceive the 'price' of smoking (or any other maladaptive behaviour) becoming greater than the reward itself. Effective use of reflective questioning can often help people to powerfully identify these triggers and the emotions they would evoke in advance – asking what they think it would take for them to quit smoking, perhaps considering how they would respond if their children began mimicking their smoking behaviour etc. People will resist the need to quit if they perceive that they are going to lose something, or someone is taking something away. It's important to find the right referential frameworks that might support them to perceive that the benefits of quitting outweigh the 'cost' of not being able to smoke. If they can see that we are helping them to 'win,' they are often very appreciative of support.

Unless a patient has a clear perception of their ability to quit, they may not be able to see the other points.

Motivational interviewing can help change this and can address some of the common misconceptions that clients often hold: that smoking helps alleviate stress, smoking is cool, quitting is too difficult, nicotine therapies are dangerous or don't work etc. Many also believe that if they fail to quit, they themselves are failures or if they don't quit 'cold turkey' then they haven't given up on their own. Mass media campaigns such as 'Smoking Not Our Future' are helping to address these misconceptions and it's also an area where health professionals can help people reframe these thoughts more positively.

What we do know is that the more quit attempts smokers make, the more likely they are to succeed. Utilising subsidised smoking cessation medicines (e.g. nicotine patches, gum and lozenges, bupropion, varenicline or nortriptyline) can also increase their chances of successful quitting, with smokers four times more likely to stay smokefree if they use a combination of behavioural support and medication. We also know that an offer of help, regardless of a patient's readiness to quit, will increase their chances of a successful quit attempt. Having support during the quit process again increases the chance of a person staying smokefree.

Each individual has his or her own reasons for their displayed behaviours and we can find out these individual reasons and then dispute and replace. As we know 'cookbook approaches' don't work, people are individuals and need to be treated as such. Motivational interviewing will

see that the fit of the approach with the client is the best predictor for success and not the theory or approach itself. In order to take control over their life, the person needs to gain and win in the situation, meaning that any successful intervention will ultimately lead to empowerment.

Regardless of the issue people are trying to confront and fix, they have usually tried many times to change and are so relieved when they finally can do it themselves. It is a huge boost to their self-esteem in general and affects all other areas of their life as if it has been a shift in thinking about themselves and their circumstances in the first place.

The vast majority of smokers want to quit but most don't know how best to approach it...you can help make this possible.

Researching the success of

Angus Hikairo Macfarlane



Angus Hikairo Macfarlane is of the Te Arawa waka and its confederate tribes in the central north island of New Zealand. The thrust of his activities is concerned with the exploration of cultural concepts and strategies that affect positively on professional practice, from which numerous publications have emanated. He has presented papers on culturally responsive educational approaches for improving motivation and learning, throughout the world. In 2003 Dr Macfarlane was awarded the inaugural Research Fellowship by the New Zealand Council for Educational Research and in 2004 his landmark book, *Kia hiwa ra! Listen to culture - Māori students' plea to educators*, was published. He has also been a recipient of a Tohu Kairangi award, a citation for academic achievement in Māori education. His book, *Discipline, Democracy and Diversity*, was published in 2007 and in 2010 he was presented with the Tohu Pae Tawhiti Award, acknowledging his contribution to Māori research. In 2011 his edited book on Restorative Pedagogies was published. Dr Macfarlane is Professor in Māori Research at the University of Canterbury and Kaihautū for the NZPS.

Māori achievers

The proverb “we learn by our failures” can be turned around to “we learn by our successes”, as espoused in the whakataukī “tama tū tama ora”. The whakataukī refers to the notion of the youngster who is enthusiastic is the one who will thrive - and the converse applies. NZPsS Kaihautū Professor Angus Hikairo Macfarlane from the University of Canterbury is looking at the qualities which make high achieving Te Arawa students successful learners. Professor Macfarlane is working with his Te Arawa tribal (iwi) colleagues Hiria McRae (Victoria University of Wellington), Dr Melinda Webber (University of Auckland) and Rotorua-based health/education consultant Dr Candy Cookson-Cox on the two-year iwi-based project, called Ka Awatea. A nationally acclaimed clinical psychologist who is based in Rotorua, Dr Averil Herbert, is the project manager.

The study based in Rotorua is a partnership project between the University of Canterbury and Ngā Pae o te Māramatanga, the New Zealand Centre of Research Excellence in Auckland. Professor Macfarlane said Ka Awatea was commissioned and is being supported by Ngā Pae o Te Māramatanga because of its collaborative and multidisciplinary aspects.

Professor Macfarlane said the aim of the project was to find out what motivated successful Māori learners then develop a “mana model” that can be used to help advance Māori achievement.

Ka Awatea, which means “the emergence of light”, stems from a pilot study carried out in Rotorua in 2009-2010 which gave the research team some indication as to what factors may be contributing to the success of young Māori scholars. These factors included the presence of good role models, parents that valued education,

and teachers who were culturally responsive and who pushed them to reach their potential. The students demonstrated self-efficacy and tended to engage themselves at school and in extra-curricular activities.

The proverb “we learn by our failures” can be turned around to “we learn by our successes”, as espoused in the whakataukī “tama tū tama ora”.

The pilot study concluded that education should be an opportunity for skilful young Māori to harness their collective strength and focus on developing innovative solutions and strategies in order to participate in the global community, as Māori. In order to succeed and to enter the global context, learners must be encouraged to see ‘being Māori’ as integral to success. The study added that the parents of these successful students immersed their children in aspects of te ao Māori. This was likely a contributing factor for their having a positive attitude of ‘being Māori’. Cultural confidence goes hand in hand with accomplishments in sport, study, and personal development as the study showed that the student participants were successful in a range of areas including sport, academic and cultural activities. The learning environment, the pilot study contended, has dual responsibilities to Māori learners: to prepare students for participation in wider society, and to prepare students for engagement in te ao Māori.

Professor Macfarlane said that *“the pilot study made us want to find out more – to dig deeper and go wider. What we’re hoping is that this study (Ka Awatea) will show us areas of distinctiveness that did not show up in the first study. One of our hypotheses is that the students will also show a firm link to their culture that gives them a*

strong sense of identity. But we can only hypothesise at this stage. The data will provide the evidence”.

The 2012-2014 study will involve interviewing and surveying over 100 Māori students in their senior years who have been nominated by their school as being someone who is excelling in their studies and other aspects of school life. A further 200 participants made up of whānau, teachers and school leaders will also be pivotal to the study. All high schools in the Rotorua area, including wharekura, have been invited to take part in the project.

Professor Macfarlane said eight qualities demonstrated by icons from the iwi’s past – identity, diligence, relationships, creativity, wellbeing, scholarship, humility and values – will be used as a benchmark for the study.

A point of difference for this project is that it will move away from the approach that has appeared to have been the accepted one up until now; the deficit theorising approach.

Once the study is completed in 2014 the findings will be produced in a manuscript and gifted by Ngā Pae o te Māramatanga to the iwi, then shared with schools, families and the Ministry of Education.

Whilst various Ministry of Education policies, including Ka Hikitia, have stipulated that Māori students should experience success ‘as Māori’ – none appears to have explained with adequate clarity what ‘success’ might look like for Māori students, whānau and communities. The Ka Awatea project aims to define, devise and test a model of success that puts Te Arawa tribal conceptualisations at the centre. Subsequently it will consider the potential for the model to spread outward from Te Arawa for trial and

adaptation.

A point of difference for this project is that it will move away from the approach that has appeared to have been the accepted one up until now; the deficit theorising approach. For decades researchers in the field of education and psychology have attempted to come to terms with the disparities that have been associated with Māori achievement by focusing on the reasons rangatahi are failing in the system. Ka Awatea is concerned that the system may be failing rangatahi but the project has no intention of apportioning blame. What Ka Awatea wants to do is reposition the emphasis simply by ascertaining the imperatives that contribute to Māori students experiencing success – and using these as benchmarks for learners, teachers, educational leaders, and psychologists who work with Māori students and their whānau. According to Professor Macfarlane, “It’s time to move forward affirmatively; Me haere whakamua tātou”.

The New Zealand Psychologists Board Accreditation Process

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The Board is currently two-thirds of the way through the process of formally accrediting psychology training programmes for the first time. This article summarises the background to this new initiative, the principles it is based on, what is involved and where each programme is up to.

The Health Practitioners Competence Assurance Act 2003 (the Act) requires the Board to prescribe the qualifications for each scope of practice and to accredit the educational courses which provide the pathways to achieving those qualifications to ensure appropriate standards are upheld. In order to carry out this

mandated task, the Board initially worked with stakeholder representatives drawn from the Heads of University Psychology Departments, the New Zealand College of Clinical Psychologists and the New Zealand Psychological Society to define the standards to evaluate each training programme against and the procedures to be followed in accrediting the programme, producing the Board’s “Standards and Procedures for the accreditation of qualifications leading to registration as a psychologist in New Zealand ” document.

This document was based on principles agreed between the Board and those with an interest. The accreditation standards should enable graduates to meet the minimum standards of the Board’s prescribed “Core Competencies for the Practice of Psychology in New Zealand”. In accordance with the obligations contained in the Act, the Code of Ethics and the Board’s Global Ends policy, the training and practice of psychologists in Aotearoa/ New Zealand must reflect paradigms and world views of both partners of te Tiriti o Waitangi /The Treaty of Waitangi and therefore the standards of training must uphold bicultural safety. The standards are intended to be high level and flexible, rather than prescriptive, to encompass the diversity of courses offered by the various training schemes. Having some variation between courses is seen as giving strength to our training environment, reflects the wide range of specialist interests, and allows applicants to approach professional psychology training from a range of pathways.

The first cycle through the formal accreditation of all the training programmes was to be one based on mutual learning as there were many unknowns, including the obvious fact that very few of the key people involved in the process have had any prior experience of undertaking accreditations. Once all programmes have been formally accredited, it is intended that the “Standards and Procedures” document will be reviewed, prior to the second round starting in 2014.

Consistent with the emphasis on learning, the first cycle was based on the principles of respectful enquiry encouraging collaboration; using the

accreditation process as a constructive review by peers and colleagues; and using the outcome as formative feedback if any weakness was perceived. It is recognised that the outcomes from an accreditation process potentially hold high and weighty significance for both student participants and those involved in delivering the programme. Therefore the emphasis was placed on finding constructive paths forward and using monitoring regimes if necessary to prompt appropriate responsiveness to feedback.

How the accreditation process operates in practice is that a three person Assessment Team (AT) is appointed to visit and assess the programme against the standards. The team habitually consists of two members with specialist knowledge aligned with that of the programme and one member who has the ability to assess the bicultural aspects. Sometimes it may be necessary to include a fourth member on the AT depending on what expertise may be required for a particular assessment. Given the relatively small and close-knit New Zealand psychology community, the appointment of a team to assess any specified programme must be done with awareness and good management of any potential conflicts of interest. Once the AT is appointed, it proceeds by reviewing the documents submitted by the programme directors and carrying out a site visit. The visit enables the team to interview, make enquiries and observe first-hand the resources available to the programme. The AT makes a report to the Board's Accreditation Committee (which acts under delegation from the Board) whose task it is to consider and moderate the report and its recommendations, and make final decisions on accreditation. The Accreditation Committee consists of

a combination of Board members, external academic representatives, and Board secretariat members.

At the time of writing (late September), eleven university and two employer based 'Supervision to Registration' programmes have been accredited. A further three programmes are in various stages of the process (one is waiting on the final report, one is waiting on a site visit, and one has just submitted documents and is therefore waiting on an AT to be appointed). Four programmes have yet to submit applications for accreditation.

The optimum outcome from an accreditation process is for accreditation to be granted for seven years. A report is routinely required after two years to inform the Accreditation Committee of any structural, curriculum or resourcing changes. Sometimes accreditation is granted for a shorter period. The AT may give feedback on aspects of perceived weakness in the programme which may prompt the Accreditation Committee to include a condition that requires the programme director to report back on the changes that have been made in response to that feedback.

The training programmes that have been accredited are: the University of Auckland's Clinical, ABA, Health, and Industrial, Work & Organisational; AUT's Counselling; Waikato's Clinical, Community, ABA, and Organisational; Victoria's Clinical; and Massey's Industrial/Organisational. In addition the Corrections and the Defence "Supervision to Registration" programmes have both been accredited. Canterbury's Child and Family psychology programme is waiting on its final AT report. Otago's Clinical programme is currently waiting for the site visit to be conducted and Massey's Clinical

programme has just submitted its application for accreditation. Programmes which have not started the process are Massey's Educational and Psychological Practice programmes; Victoria's Educational psychology programme; and Canterbury's Clinical programme.

The interested reader who wishes to enquire about the outcome for any particular course can check the Board's website under the heading "Education providers and students" as the final accreditation report for each programme is published there. The documents associated with accreditation processes are also posted. The review of the "Standards and Procedures" accreditation document will be signalled nearer the time and will be open for consultation.

Accreditation helps ensure students receive high quality training, protects members of the public by ensuring high standards are maintained by the graduates, and helps give our psychologist graduates international credibility. The Board is very appreciative of the generous contributions of time and effort by all of those who have contributed to the process. Preparing an application for accreditation is a large and demanding task which has to be fitted in around the usual tasks in a learning programme. The AT members are all busy professionals who take on this role as an extraordinary contribution to the psychology profession. The external Accreditation Committee members provide representation of the wider academic community. Thank you to all who have been involved in this important process which has significance for all psychologists, regardless of whether or not they have direct connections to training programmes.

Abstracts of Students' Theses

Tena koutou katoa,

In this issue we continue a recent innovation to present recent abstracts from Masters and PhD research theses completed in 2011 and 2012. In previous issues of *Psychology Aotearoa*, we provided abstracts of research completed in industrial/organisational psychology (May 2011) and community psychology (November 2011). For the present issue, we focus on research in clinical psychology. Here we list abstracts from the University of Canterbury, University of Otago and University of Waikato. The aim is to provide information on the range of research which is being conducted at universities in Aotearoa New Zealand, in a form which is valuable for both practitioners and researchers.

Unfortunately, we are not able to include abstracts from The University of Auckland or Massey University in this issue, but we hope to be able to do so on another occasion. If you would like further information on any specific abstract, we suggest that you make direct contact with the chief supervisor of that thesis. If you have any general comments on this section, we would appreciate hearing from you.

Ngā mihi nui,

Michael O'Driscoll, Editor

University of Otago

Alder, Roni (MSc, 2012)

Title: *The acute impact of news of risk for schizophrenia: Ethical implications of psychometric screening*

Supervisor: Richard Linscott

Background: In the psychometric high-risk paradigm, contrary to the principle of informed consent, participants are not usually informed of their risk status. One argument for this nondisclosure is that risk information may engender significant distress.

Objective: The aims were to investigate this argument and to examine the reactions of non-help seeking individuals to disclosure of personally relevant information about risk for schizophrenia. It was expected that the impact of news of risk for schizophrenia would be similar to that associated with cancer and greater than that associated with depression and a neutral control condition. It was also expected that stigma consciousness and health locus of control would predict distress arising from the news. **Method:** Participants (N = 160) underwent screening in a deception paradigm (thioamine acetylase enzyme deficiency) during which the participants were led to believe they had an enzyme deficiency that was benign (neutral control) or associated with elevated risk for schizophrenia,

cancer, or depression. Participants provided subjective mood ratings, salivary cortisol pre- and post manipulation, and rated beliefs about stigmatisation and health locus of control.

Results: Low levels of subjective and objective distress were observed. There was no evidence that the impact of news differed across groups or that health locus of control predicted distress. Greater expectations of being stigmatised predicted greater deterioration in self-reported mood. **Conclusions:** The study helps to progress the research available on schizotypy screening and contributes to the debate surrounding this area. Given the findings, it is possible that the concern participants could experience distress upon receiving news of risk may not be well-founded.

Bekker, Marthinus (MSc, 2011)

Title: *Improving asthma self-management in tertiary students*

Supervisor: Louis Leland

New Zealand is rated seventh highest in the world for the prevalence of asthma, with an estimated 15.1% of the population suffering from this disorder. Poor management of the condition contributes to the severity of the problem despite the availability of adequate treatments. Patient compliance with asthma medication regimes is poor, and the tertiary student population is a particularly noncompliant group with

self-reported adherence as low as 44%. The current study had three main aims. The first was to test a method of increasing asthma medication adherence, the second was to improve participants' technique when using their inhalers, and the third was to make participants aware of the positive outcomes associated with reaching the first two aims and provide them with general education. The intervention used proximal pairing, education, and feedback. Proximal pairing was used as a memory aid, with participants' inhalers put in a holder along with their toothbrush and toothpaste. Education focused on inhaler technique, and asthma's triggers and treatment. Feedback on participants' asthma symptoms, peak flow readings, and technique, was provided at regular intervals. These interventions had a significant positive effect on both adherence and technique, both overall, and for many of the individuals, as well as significantly improving their overall opinion that taking their preventative inhaler reduced asthma symptoms. The results show that days on which preventative inhalers were used at least once increased by 21% after intervention among participants who had poor adherence before intervention. Inhaler technique also improved significantly from 74% accuracy before the intervention to 93% after. Furthermore, the number of people who believed that taking their inhaler was important also increased significantly. These

changes were accompanied by an overall significant increase in peak flow, although few individuals achieved a meaningful increase and there was no change in reliever usage. The changes were achieved while maintaining good social validity and at a cost of only about NZ\$20 per person per year. These results show promise in not only improving asthma medication management with a simple and affordable intervention, but also for improving adherence of other chronic medicated conditions.

Harding, Jasmine (MSc, 2012)

Title: The impact of children's ADHD symptom severity and maternal characteristics on mothers' psychosocial functioning

Supervisor: Dione Healey

A growing body of research has shown that childhood Attention Deficit Hyperactivity Disorder (ADHD) is linked with psychosocial difficulties in parents, specifically in mothers who tend to be heavily involved in the day-to-day care-giving of their child. The present study aimed firstly to replicate the finding that maternal psychosocial difficulties are greater in mothers of children with ADHD than in mothers of typically developing children. Secondly, the study aimed to examine the relation amongst maternal characteristics, maternal psychosocial functioning, and child ADHD symptom severity in order to identify factors associated with increased vulnerability to psychosocial difficulties. Thirdly, we investigated the moderating effect of maternal personality, parenting practice, and coping on the relationship between child ADHD symptom severity and maternal psychosocial functioning (e.g., depression, anxiety, and stress). Participants were 60 mothers and their children aged 6 to 12 years old (28 ADHD, 32 controls). Measures of maternal personality, parenting practice, coping style, and psychosocial functioning were obtained using standardised questionnaires. Independent samples t-tests identified that mothers of children with ADHD experienced higher levels of psychosocial difficulties than mothers of typically developing children. One tailed bivariate correlations showed that various maternal characteristics, psychosocial functioning factors, and child ADHD symptoms were inter-related. Multiple regression analyses revealed moderating effects of neuroticism,

agreeableness, extroversion, engaged parenting, and coping on the relationship between child ADHD symptom severity and maternal psychosocial functioning. Taken together, the results suggest that mothers of children with ADHD are adversely affected in terms of their psychological health. Findings are discussed in terms of how they may supplement current psychological interventions.

Hegan, Matt (MSc, 2011)

Title: Gambling behaviour in pigeons: Toward an animal model of gambling

Supervisor: Mike Colombo

The gambling addiction is a destructive impulse control disorder that leaves families destitute and lives in ruins. The treatment and pathology of gambling has become a popular area of research, reflected in national media campaigns here in New Zealand. Studies suggest that there are prefrontal activation differences in problem gamblers compared to healthy volunteers, areas involved with decision making and reward. Animal research has begun to investigate an animal model of gambling, with some studies showing behavioural similarities between animals and humans when playing gambling tasks.

The current thesis sought to further investigate an animal model of gambling, performing two experiments using a slot machine task. Experiment 1 was an investigation into the neural basis of gambling, examining the behaviour of single neurons in the avian NCL, an equivalent to the mammalian prefrontal cortex. Four pigeons (*Columba livia*) served as subjects and played a touch screen slot machine task, similar to a slot machine found in any casino. Pigeons were required to peck an upright arm to initiate each trial, and then peck four rolling tumblers in succession from left to right. If four identical stimuli appeared, then a wheat reward was won. During the task, activity from single NCL neurons was recorded. Four neuronal types were found to correlate with gambling related behaviour: Reward Proximity neurons, I-Won neurons, I-Lost neurons and Near Win neurons. In addition pigeons were split into two groups with one group trained for a short (one month) and long (four month) period, in an attempt to mimic naive and problem gamblers. It was hypothesised that due to prolonged training the two groups would differ in

the amount and magnitude of firing of these neurons. Results showed no statistical difference between groups in either amount of gambling neurons or magnitude of firing. Behavioural data were also collected and it was hypothesised that all birds would show evidence of a post reinforcement pause, something our results confirmed.

Experiment 2 investigated whether pigeons, similar to humans, show a preference to play slot machines with higher near win ratios. Four pigeons were again tested on a touch screen slot machine task, required to play on two different 'machines' differentiated by different coloured backgrounds. It was hypothesised that when pigeons were given a choice, they would choose the machine that had the higher percentage of near win trials. Our results did not show evidence of any preference, and it was concluded that the near win effect may not be replicable in animals.

In conclusion, the current thesis demonstrates that neurons in the avian NCL code for gambling behaviours while pigeons play a slot machine task. Although an analogue of slot machine gambling may be found in animals, our findings suggest gambling characteristics such as the near win effect may not be replicable. The current findings provide a base for further research to investigate an animal model of gambling.

Lim, Bee Teng (PhD, 2011)

Title: The ubiquitous decline or paradox of aging: Young and older adults' differences in emotion reactivity, recognition, and regulation

Supervisor: Ted Ruffman

The aging literature indicates that physical, cognitive and affective functions follow different trajectories across the lifespan. Physical and cognitive capabilities are shown to decline with advancing age, whereas affective functioning is suggested to remain stable or may even be enhanced in older adults. The main aim of the present thesis is to examine age differences in emotion reactivity, recognition and regulation. The inter-relationships among emotion reactivity, recognition and regulation were also assessed to provide a more complete picture of potentially different age trajectories of emotion processes. In addition, the effects of potential moderators, namely emotion intelligence and loneliness, on age differences in emotion reactivity were examined. In Study I, a standardised set of film stimuli

was developed and validated. Forty-eight participants (24 young and 24 older adults) participated in the stimulus validation study. The chosen film stimuli were shown to be effective in eliciting target emotions in a laboratory setting. No significant age and sex differences were observed, and prior viewing of the film was shown to have no significant impact on participants' self-reported emotion experience.

In Study II, young-old differences in emotion reactivity, recognition and regulation as well as the inter-relationships among these affective functions were of interest. In addition, age-related decline in heart rates and skin conductance levels in response to affective film stimuli were observed. Older adults were significantly worse at recognising facial expressions of sadness and anger, and marginally worse at recognising facial expressions of fear. Older adults reported more habitual use of expressive suppression than their younger counterparts, while no age difference was found for cognitive reappraisal use. Emotion intelligence did not buffer against age-related decline in emotion reactivity.

Finally, in Study III, I aimed to replicate the findings of Study II, as well as extend Study II by including facial electromyography as another index of emotion reactivity. I also employed emotion recognition tasks that are more complex and tap into other sensory modalities. Again, age-related decline in heart rates and skin conductance was observed. Young adults displayed significantly greater corrugator activity in response to fear-provoking film clips, but no significant age difference was found for corrugator activity in response to the anger and sadness-provoking film clips. Young and older adults also displayed comparable level of zygomatic facial activity when presented with the amusing film clip. Older adults were worse at recognising angry and fearful facial affect. As for the face-voice and body-voice matching tasks, older adults were worse at recognising all emotions except for surprise. Older adults also reported more habitual use of expressive suppression, and that was shown to affect emotion recognition performance.

Taken together, these studies indicate that different components of affective functions are differentially affected by normal adult aging. Implications for competing perspectives of socioemotional functioning in older adults as well as suggestions for

positive aging are provided.

McEachen, Benjamin (PhD, 2011)

Title: A putative model of attention deficit hyperactivity disorder

Supervisors: Gail Tripp and Brent Alsop

ADHD is a commonly diagnosed disorder of children, and is characterized by difficulties with inattention and/or hyperactivity/impulsivity. Some theories and models of ADHD have noted that children with ADHD respond differently from controls to rewards. The two studies in this thesis used response bias (log b, a measure derived from signal detection theory) during a computerized detection task to examine the response to rewards in children with ADHD. The participants were children aged between 6 and 12 years of age. One hundred and fifty two children were recruited from Dunedin schools, and 136 children were referred by the Otago District Health Board for assessment of ADHD related difficulties. From these two groups of children 68 boys with combined type ADHD (ADHD-C) and 91 normally developing boys were identified. Both studies used a similar computer task to present stimuli and measure responses. A matrix of computerized characters was presented on a computer screen. Participants were asked to identify whether there were more red or more blue characters present. Correct responses were occasionally rewarded with an on-screen animated cartoon, verbal praise from the examiner, and tokens which were exchanged for a small gift at the end of the task. Study 1 examined sensitivity to reward frequency, and generated response bias by arranging more frequent rewards for correct responses to one stimulus than the other stimulus. Study 1 found that boys with ADHD-C developed bias towards more frequently rewarded stimuli more slowly than normally developing boys - this was particularly apparent towards the end of the task. The results were also consistent with previous literature identifying that children with ADHD show reduced bias towards frequent rewards following individual rewards to the infrequently rewarded stimulus. Study 2 examined sensitivity to reward delay, and was designed to generate response bias by arranging immediate rewards for correct responses to one stimulus and delayed rewards for correct identifications of the other stimulus. In Study 2 there were no clear differences between groups. The

interpretation of both experiments was confounded by confounding variables: task version (in Study 1); and task order (in Study 2). An unintended but interesting finding is that children with ADHD-C may be more influenced by their past history of reward than control children. Children with ADHD-C who completed Study 2 after Study 1 tended to continue to show bias towards the response that had been rewarded frequently in the previous task, despite the same response being associated with delayed rewards in the current task. Children with ADHD-C may be less able than normally developing children to reverse their preference in response to altered reward contingencies. The results of the current experiments are discussed in relation to the broader literature on ADHD and rewards/reinforcement and current theories of ADHD.

McLennan, Kathryn (MSc, 2012)

Title: Evaluation of the New Zealand Word Identification Fluency Task as an Indicator of Reading Proficiency in Year 2

Supervisor: Libby Schaughency

Many reading difficulties may be prevented if detected and effectively addressed early (Greenwood & Carta, 2011). In New Zealand, recent policy documents specify instructional targets after one year of school (Ministry of Education, 2009). Therefore, assessment tools are required for this developmental period that are effective and efficient.

Some aspects of beginning reading, such as learning the alphabet, may be constrained, no longer growing once they are achieved due to ceiling effects (Paris, 2005). However, because reading skills are still developing, oral passage reading tasks may not be sensitive to individual differences and change in performance until approximately the middle of Year 2 due to poor effects. A measure is required that adequately indexes children's developing reading proficiency during this intermediate period. Research suggests that context-free word recognition speed contributes to syntactic processing in reading (Klauda & Guthrie, 2008) and differs between skilled and unskilled readers (Jenkins, Fuchs, Van Den Broek, Espin & Deno, 2003). Fuchs, Fuchs and Compton (2004) found Word Identification Fluency (WIF) to be a good indicator of overall reading proficiency

among Year 2 aged children in the US. Due to linguistic (Robb, Maclagan, & Chen, 2004; Robb & Gillon, 2007) and curricular (Smith & Elley, 1997) differences between NZ and America, small-scale field trials are recommended before introducing measures to the New Zealand educational context (Croft, Stafford & Mapa, 2000).

This thesis aimed to create and evaluate a New Zealand adaptation of the WIF task (NZWIF). Following the approach taken by Fuchs et al. (2004), we developed New Zealand Word Identification Fluency (NZWIF) for the New Zealand (NZ) educational context, informed by research on the development of word usage by children in NZ and consideration of words NZ children encounter in beginning reading texts.

Pharo, Henry (PhD, 2012)

Title: The behavioural and psychological effects of ostracism in adolescence and emerging-adulthood

Supervisor: Harlene Hayne

The developmental periods of adolescence (13- to 18-yearst and emerging-adulthood (18- to 25-years) are important stages for an individual's emotional and psychological development. For most, adolescence and emerging-adulthood are times of excitement, a time in which they mature and develop a deeper sense of personal identity. However, there is also a subset of the general population who can develop psychological problems such as substance abuse disorders, delinquency, depression, and suicide during this time. While the aetiology of these problems is not entirely clear, a number of researchers have shown that one of the biggest external predictors of problem-behaviour during adolescence and emerging-adulthood is peer influence.

Ostracism -the act of being excluded or ignored by others is one aspect of peer influence that warrants considerable scientific attention. A large body of research has shown that ostracism is associated with a decrease in an individual's psychological well-being, including their self-esteem. Furthermore, work conducted both within our own laboratory and in others has suggested that adolescents and emerging adults may be at an increased risk of experiencing negative effects following ostracism.

The overall aim of this thesis was to investigate the psychological and behavioural

impacts of ostracism in adolescent and emerging-adult samples. In Experiment 1, we recruited samples of adolescents, emerging-adults, and young-adults, and examined whether ostracism would influence participants propensity to assert control over a group situation by nominating themselves as a leader. For Experiment 2 and Experiment 3, we chose to focus our investigations on the emerging-adult population. In Experiment 2 we examined the relation between ostracism and risk-taking behaviour, and in Experiment 3 we examined the relation between ostracism and aggressive behaviour, and the effect of being ostracised by a group of close friends compared to a group of strangers.

Overall we found a number of interesting findings. First, consistent with the ostracism literature, in all three of our experiments we found that ostracism had a strong negative effect on participants' psychological well-being. Second, we found a number of specific effects of ostracism on participants' behaviour. In Experiment 1 we found that individuals who reported the greatest negative effect of ostracism on their self-esteem were more likely to nominate themselves for a leadership role; this may be one way in which individuals who are worst affected by ostracism attempt to buffer and re-build their diminished self-esteem. In Experiment 2 we found that ostracised participants were significantly less likely to take risks on a computer based risk-taking task compared to included participants, therefore suggesting a link between ostracism and introverted behaviour. Finally, in Experiment 3 we found two findings; first, despite prior research suggesting a link between ostracism and increased aggressive behaviour, we found no effect of ostracism on aggression in our sample. Second, counter to the current theoretical models of ostracism, the magnitude of the negative effect of ostracism did not differ as a function of the source of ostracism. That is, individuals who were ostracised by complete strangers or by close friends both reported equal levels of psychological hurt. Overall this thesis provides new insight into the psychological and behavioural symptoms associated with the experience of ostracism.

Reid, Katie (MSc, 2011)

Title: The pursuit of happiness

Supervisor: Tamlin Conner

Is the frequent monitoring of happiness in

daily life actually detrimental to happiness?

Current psychological literature suggests that explicit focus on happiness may actually be self-defeating (Schooler, Ariely, & Lowenstein, 2003). The current thesis investigated the psychological effects of frequent self-monitoring of happiness outside the laboratory in daily life. A total of 223 young adults (92 men) from the University of Otago were randomly assigned to one of four experimental groups. Commercially available SMS text message software was used to send participants either one, three or six text messages per day for 13 days inquiring about their current level of happiness. A fourth control group also received six text messages per day inquiring about non-mood related experiences. Findings showed no differences in changes in momentary or trait happiness between the three experimental groups, suggesting no reactivity as a result of monitoring happiness overall. Conversely, group differences in changes in momentary happiness were moderated by personality variables self-esteem and dysphoria. Findings suggested that increased monitoring of happiness among those with low self-esteem and high dysphoria leads to a decrease in happiness over time. Interestingly, there was also some evidence that frequent reporting of non-emotional states led to a decrease in trait happiness among those low in self-esteem. Taken together, these findings suggest that the heightened focus on happiness throughout western society today may actually be detrimental to the happiness of those with greater vulnerability to lower mood - i.e. those with low self-esteem or high dysphoria.

Robinson, Thomas (PhD, 2011)

Title: Neuropsychological function and ADHD

Supervisor: Gail Tripp

The present study compared the intellectual, academic, and neuropsychological performance of 55 children diagnosed with attention deficit hyperactivity disorder (ADHD) with that of an age and gender matched control 4 years after initial diagnosis. The performance of the ADHD group at initial-assessment and at four years follow-up was also compared at both the group and individual levels of analysis. Cross-sectional comparisons indicated the ADHD sample performed less well than controls on measures of intellectual function, academic achievement, and on some

neuropsychological measures. Subgroup analyses suggested participants whose symptoms had remitted were less impaired relative to controls. Longitudinal group comparisons found little evidence of change over the course of the study. However, higher than expected proportions of reliable change at an individual level were observed for intellectual function and especially for academic achievement.

Stedman, Kurstyn (MSc, 2011)

Title: Obesity and intellectual disability in New Zealand

Supervisors: Louis Leland and Gareth Treharne

International literature indicates that the rates of obesity are increasing in OECD countries and that there are significant health risks to individuals who are classified as obese. Research has also highlighted that obesity is likely to be more pronounced in people who have an intellectual disability (ID). Despite this association there has been little research into the reasons why this population is overrepresented in obesity statistics. Furthermore, except for the brief report derived from this thesis (Stedman & Leland, 2010), there are no published New Zealand data on the rates of obesity among people who have an intellectual disability. In the present study I accessed a database containing anonymous data for a sample of New Zealanders who have an intellectual disability. Ninety-eight participants out of 141 in the database had complete and up to date data. The group with complete data did not significantly differ from the group with incomplete data in gender or hours of staff support. Participants' body mass index (BMI) was used to estimate rates of obesity within the sample. Comparisons were made with the general rates of obesity in adults reported by the New Zealand Ministry of Health (2008) using each of the BMI categories; underweight (< 18.50), normal (18.50 - 24.99), overweight (25.00 - 29.99) and obese (≥ 30.00). Obesity was further broken down into classes one (30.00 - 34.99), two (35.00 - 39.99) and three (≥ 40.00).

There were significantly higher rates of people with a BMI ≥ 30.00 , in the group who had an intellectual disability (50.98%; general population 26.50%). There were significantly more adults who had an intellectual disability in all three BMI classes, with the most significant difference in class

three.

While there were more obese men and women who have an intellectual disability in this sample than would be expected, women were found in higher than expected rates in class two (BMI 35.00 - 39.99) and class three (BMI ≤ 40.00). Research into the causal factors and potential interventions specific to men and women in this population to promote and maintain weight loss are warranted.

Stevenson, Matthew (MSc, 2011)

Title: Do Phenylketonuria and Attention Deficit/Hyperactivity Disorder Share a Common Dysfunction? A "Behavioural Inhibition System" Hypothesis

Supervisor: Neil McNaughton

Phenylketonuria (PKU) is a well defined metabolic disorder arising from a point mutation on a single gene. This mutation disrupts the metabolism of phenylalanine, which indirectly reduces the synthesis of dopamine. Severe cognitive impairment can be prevented by dietary treatment; however, residual symptoms may be reported.

These symptoms appear closely related to a more prevalent childhood disorder: Attention Deficit/Hyperactivity Disorder (ADHD). The aetiology of ADHD is a vast contrast to PKU: it seems to arise from a complex combination of genes; and it has a substantial environmental component. These two disorders provide an opportunity to compare two vastly different genotypes that seem to converge on a specific phenotype. This thesis provides a comprehensive review of the literature on PKU, including aetiology, treatment, neural pathology, cognitive deficits and electrophysiological abnormalities. Where available, studies from the ADHD literature were matched for comparison. This comparative review found distinct neural pathologies that nonetheless had points of similarity that could underlie similar superficial symptom clusters. Overlapping symptoms between PKU and ADHD included deficits in visual function, motor function, attention, working memory, planning and inhibition.

It has been suggested for both disorders that many of these cognitive deficits may arise from a primary deficit of behavioural inhibition. The primary behavioural inhibition deficit in ADHD (excluding the inattentive-subtype) has been explicitly linked to the Behavioural Inhibition System

proposed by Gray & McNaughton (2000).

The current thesis proposes that PKU and ADHD share this dysfunction of the Behavioural Inhibition System, which leads to superficial symptoms being common to both disorders. One role of the Behavioural Inhibition System is to resolve conflict between two competing goals. Therefore, an ideal task to test this hypothesis should: 1. Be a pure measure of behavioural inhibition, unconfounded by other abilities that may be deficient in PKU and ADI-ID; 2. Produce conflict-specific activation of the Behavioural Inhibition System.

The Stop Signal Task is one of the simplest tests of behavioural inhibition and has been recently used to produce conflict-specific theta rhythm activation in healthy adults. This provides a marker of activation of the Behavioural Inhibition System. The thesis ends with the first demonstration that the Stop Signal Task can be used to produce conflict-specific theta activation in healthy children. The hypothesis that PKU and ADHD share a common dysfunction of the Behavioural Inhibition System can therefore be directly tested.

Vettise, Dominic (MSc, 2012)

Title: Visual elements of schizotypy experiences: An investigation of representational momentum and eye-tracking risk markers

Supervisor: Richard Linscott

Eye tracking dysfunction including smooth pursuit and voluntary eye movement are the most robust biological markers for risk of schizophrenia. Researchers suggested that eye tracking impairment may also involve higher-order functions such as errors in the prediction of an object's position, yet the relationship is unclear. Therefore, prediction of an object's position was tested through a unique phenomenon observed in schizophrenia and those at risk coined the representational momentum (RM) effect. The aim of the current study was to determine whether the prediction of an object's position is involved in eye movement anomalies and to what extent eye tracking and prediction is differently related to aspects of schizotypy. It was hypothesised that a) the eye tracking indices would be differently related to schizotypy subtypes, and b) the RM effect would significantly contribute to a model predicting risk for schizophrenia. One hundred and seventy-one participants were assessed on evidence-based eye tracking

tasks that measured pursuit gain, the visual grasp reflex (VGR), and a RM task. These measures were combined to provide a model that could predict psychometric risk of schizotypy, using the Schizotypal Personality Questionnaire (SPQ). Each of the eye tracking measures were differently related to risk, but, together as a model they were not able to determine risk. More specifically, RM did not significantly contribute to the prediction of risk when it was added to a multiple regression model. Although the results were not consistent with all the current study's hypotheses, there were positive initiatives for the RM and eye tracking. It was concluded that the RM effect has the potential to improve the understanding of eye tracking dysfunction in schizophrenia. However, future research needs to be carried out to better understand the role of RM.

Wolff, Amy (PhD (Neur), 2011)

Title: Brain and behaviour in an animal model of schizophrenia

Supervisor: David Bilkey

Schizophrenia is a chronic neurological disorder that causes significant impairment for ~1% of the population. Epidemiological studies have suggested that there is a link between prenatal exposure to infection and the development of schizophrenia in the progeny. In particular, maternal immune activation (MIA) in response to infection is thought to alter neurodevelopment so as to increase the risk of schizophrenia. The MIA animal model provides a useful platform to examine this link, as it separates the effects of infectious factors from immune activation. Here, the effects of MIA in the rat are characterized, with a particular focus on memory function and contextual processing, as these have been proposed to be core features of the cognitive symptoms of the disease. The contributions of the hippocampus to cognitive impairment in schizophrenia are also explored. MIA was induced in pregnant rat dams on gestational day 15 with a single injection of the synthetic cytokine inducer poly I:C. Open-field exploration and pre-pulse inhibition (PPI) were assessed in juvenile (35 day) and adult (> 3 month) offspring. Discrimination and reversal learning, memory function and contextual processing were assessed in adult animals. A separate group of adult animals were implanted with electrodes in the dorsal hippocampus for an

in vivo examination of hippocampal place cell activity.

MIA offspring were shown to display impaired PPI during testing conducted in adolescence and in adulthood. The MIA animals were also found to display abnormally rapid reversal learning of a position discrimination. MIA also resulted in memory impairment, with MIA animals displaying significantly reduced preferences for the novel object during recognition testing, and an increased memory for the reversed platform position in the Morris water maze task. MIA offspring also displayed evidence of impaired contextual processing, showing a reduced and less persistent reinstatement of rearing after a change in environmental context. The in vivo examination of hippocampal place cell activity indicated that cells in MIA offspring display a more spatially selective representation of 'place' than control cells. MIA animals were also less likely to shut down or turn on their spatial firing in one of the environmental contexts, indicative of reduced context specificity.

Here it is demonstrated that MIA in the rat produces behaviours that are similar to the positive and cognitive symptoms seen in patients with schizophrenia. We have demonstrated for the first time that MIA results in a similar disruption of sensorimotor-gating and non-spatial memory in the adult rat, as has previously been reported for mice. Interestingly, we found that PPI impairments in the rat do not display the same post-pubertal pattern of emergence that is seen after MIA in the mouse. We have also shown for the first time that MIA is associated with impaired contextual processing, a disruption that is thought to be a core underlying deficit in schizophrenia. The examination of hippocampal place cell activity also suggested a reduced sensitivity to contextual information in the MIA animals. These results suggest reduced context-specificity of hippocampal representations may be a factor underlying contextual processing impairments in schizophrenia.

Zdrenka, Helene (MA, 2011)

Title: Predictors of impairment in school-aged children with a diagnosis of ADHD

Supervisor: Dione Healey and Gail Tripp

Background: Many children exhibit hyperactive/inattentive behaviours, but only

some experience significant impairment. However, little is known about the reasons some symptomatic children are more impaired than others. This study examined whether child, paternal, or teacher factors predicted level of functioning in school-aged children diagnosed with ADHD, above and beyond child ADHD symptom severity. Method: A sample of children aged 5 to 11 years who were all diagnosed with ADHD (n = 88), participated in this study. Child measures included FSIQ scores, parent and teacher reported ADHD symptom severity and temperament attributes, and clinician-rated Children's Global Assessment Scale (CGAS) ratings which were used to determine level of child functioning. Parent- and teacher-rated child expectations and actual child behaviour, parenting/teaching stress, and parent reports of parenting style were obtained. Results: Analyses showed that after controlling for child ADHD symptom severity, lower maternal parenting-efficacy beliefs was significantly associated with higher maternal stress and maternal parenting styles. Higher child ADHD symptom severity and a lax maternal parenting style were significantly related to higher child impairment above and beyond maternal parenting beliefs. After controlling for child temperament attributes, paternal stress was approaching significance to an over-reactive paternal parenting style, which was in turn approaching significance to child functioning, above and beyond child temperament attributes. After controlling for child ADHD symptom severity, higher teacher responsibility for student failure, lower teacher credit for student success, and lower Goodness of Fit (GoF) between teacher expectations and student behaviour in regard to general activity level and adaptability to changes, were significantly associated with higher teaching stress, above and beyond child ADHD symptom severity. Lower teacher credit for student success and lower teacher expectations GoF in regard to adaptability were approaching significance in relation to higher child impairment, above and beyond child ADHD symptom severity, teacher attributions for student failure, and teacher expectations GoF in regard to general activity level. Conclusions: Child, parent and teacher factors were related to level of impairment in school-aged children with ADHD, with strongest effects found for maternal factors. The results suggest that ADHD interventions for school-aged

children which help mothers to develop greater parenting-efficacy beliefs may help reduce parenting stress and maladaptive parenting. Furthermore, teaching mothers strategies to better manage parenting stress, along with firm and consistent parenting behaviours, may improve the functioning of school-aged children with ADHD. Fathers of children with ADHD may benefit particularly from gaining parenting stress management skills in order to better control expressed irritability towards their child while maintaining a clear communication style with them. Involving teachers in ADHD interventions by encouraging development of more balanced teaching beliefs about student success, as well as strategies to better manage teaching stress and student behaviour which deviates from teacher expectations (particularly in regard to activity level and adaptability), may also increase the functioning of school-aged children with ADHD.

Victoria University

Burrows, Michael (MSc 2011)

Title: *The influence of spatial position on affect*

Chief supervisor: Tony Ward

Conceptual metaphor theory posits that the physical domain (e.g. the vertical dimension) is used to understand abstract concepts (e.g. affect); creating expressions such as, “falling into a deep depression.” Previous research concerning vertical metaphors has found that people more rapidly process positive and negative words when the valence was metaphorically consistent with vertical position (Meier & Robinson, 2004) and that mood traits were metaphorically consistent with vertical attentional biases (Meier & Robinson, 2006). The purpose of the current study was to investigate the effects of vertical perceptual biases on mood; whether shifting perception could have an effect upon the emotional experience of an individual. In Experiment 1, vertical attention was manipulated by having university students move letters upwards or downwards on a computer screen, with measures of mood completed before and after the manipulation. In Experiment 2, participants completed the same task, but moved schematic faces that were either happy or sad. In both experiments vertical attention was biased; however a significant

change in mood state was produced only when schematic faces were used as stimuli in the task. The results suggest that shifting an individual's vertical perception can influence their mood, when the task is emotionally arousing.

Dalrymple-Alford, Stefan (MSc, 2011)

Title: *“The Cuscus has White Teeth.” The Verbal Information Pathway to Fear in Non-clinically Anxious Children: No Influence of Ambiguous Information or Trait Anxiety*

Chief supervisor: Karen Salmon

Twenty-nine non-clinically anxious children, aged 7-10 years old, completed the Fear Beliefs Questionnaire (FBQ; Field & Lawson, 2003) before and after the presentation of verbal ambiguous information about an unknown animal, while 32 similar children matched for trait anxiety did the same after hearing threat information. Behavioural avoidance of the animals was subsequently examined with an adaptation of the Nature Reserve Task (NRT; Field & Storksen-Coulson, 2007). Children also completed a Reduced Evidence of Danger interpretation bias task (Muris, Merckelbach & Damsma, 2000c) for ambiguous stories with generalised anxiety and social anxiety content, prior to the FBQ and NRT. Verbal threat information substantially increased FBQ ratings and NRT distance from the tagged animal, whereas ambiguous information had no effect on these measures other than a subset of children showing an avoidance of the tagged animal in the NRT. Contrary to expectations, level of trait anxiety was not related to interpretation biases, or the effect of ambiguous or threat information. In the threat group, but not the ambiguous group, two bias measures for generalised anxiety stories were associated with relative increase in FBQ ratings for the tagged animal, and a third bias measure for social anxiety stories was associated with NRT score. The associations held when controlling for gender, age, and trait anxiety, including trait anxiety used as a moderator variable. These findings support the view that verbal threat information is sufficient to induce fear of animals in children. Results are inconsistent with the current view that the effects of the verbal information pathway increase as a function of trait anxiety and that ambiguous verbal information can lead

to increased fear responding. The evidence for bias – verbal threat associations suggests that future studies should examine their role in the verbal information pathway to fear and anxiety, and clarify the influence of various internalising and externalising psychopathologies beyond trait anxiety.

Hardley, Jessica (MSc 2012)

Title: *An Integrated Framework for Professional Ethical Thinking in Child Clinical Psychology*

Chief supervisor: Tony Ward

Practitioners face a number of unique challenges in child clinical psychology, particularly around areas such as competency, consent, confidentiality, and the balance of obligations towards the child or young person and their legal guardians. Resorting to ethical codes of practice to try and deal with these ethical dilemmas often fails to resolve the problem adequately, or leads to ‘moral blindness’ in which other ethical issues are ignored (Ward & Syversen, 2009). In order to provide a more complete ethical guideline for practitioners to consult when faced with ethical quandaries, I have created the Integrated Framework for Professional Ethical Thinking (IFPET) that is specifically tailored towards child and adolescent clinical psychology. The IFPET model provides a multi-faceted approach to ethical thinking that widens moral reasoning and awareness and promotes a more complete approach towards dealing with ethical issues in child and adolescent clinical psychology.

Hewson, Gary (MSc 2011)

Title: *Evaluation and recall of valenced stimuli as a function of spatial position.*

Chief supervisor: Tony Ward

Meier and Robinson (2004) had subjects identify pleasant and unpleasant words presented individually either at the top or bottom of a computer screen. Subjects identified pleasant words faster when they appeared at the top of the screen and unpleasant words faster when they appeared at the bottom of the screen. The authors discussed this finding in terms of metaphors noting that in language good things are often allocated upwards (e.g. “things are looking up for me”) and bad things downwards (e.g. “I’m down in the dumps”). The aim of the present study was to investigate whether

this relationship between affective stimuli and visual space occurs automatically (implicitly) or whether explicit processing of affective stimuli is required. A second aim was to investigate if memory for affective words is influenced by spatial location. In Experiments 1 and 2 subjects were shown pleasant and unpleasant words presented either at the top or bottom of a computer screen. Half the words were coloured green and half coloured purple. Subjects had to identify the colour as quickly as possible. No significant interaction between stimulus valence and spatial position was found, nor did recall interact with spatial position. In Experiment 3 subjects had to explicitly identify the valence of the words shown either at the top or bottom of the screen. It was predicted that positive stimuli would be explicitly evaluated faster and recalled more accurately when shown at the top of the screen, with the opposite holding true for negative stimuli. Participants were quicker to identify positive words at the top of the screen. Recall did not interact with spatial position. Overall the results of this study were broadly supportive of the hypothesis for explicit evaluation but not so for implicit evaluation or recall.

Mosenrose, Sara (MSc, 2011)

Title: Faces and orientational metaphors: The effects of valenced faces and facial manipulations on neutral targets

Chief supervisor: Tony Ward

Previous research has shown that there may be an association between affect (negative vs. positive) and vertical position (up vs. down) of stimuli. The following research aimed to investigate whether individuals show spatial biases, either up or down, when asked to respond to neutral targets after seeing valenced faces. The research also aimed to investigate what impact manipulating automatic facial mimicry responses would have on response times. The research was conducted over three experiments. In Experiment 1, participants responded to neutral targets in either high or low vertical positions on a computer screen that were preceded by happy and sad schematic faces. There were two facial manipulation conditions. One group held a straw between their lips to inhibit smiling and another group held a straw between their teeth to facilitate smiling. A third group performed the response task without a straw (control

condition). The procedure of Experiment 2 was identical to Experiment 1 except the happy and sad schematic faces had additional internal facial features (noses, eyebrows) that varied across trials. For both Experiment 1 and 2, targets preceded by a happy face were responded to significantly faster. In Experiment 3, the procedure was identical to Experiments 1 and 2, except photographic images of happy, neutral, and sad expressions were used. Participants were significantly faster to respond to targets in the high vertical position. Participants were also faster to respond to targets in the control (no straw) condition than the other two straw conditions. In the inhibition smiling condition, participants were faster to respond to targets in the high vertical position than low vertical position after seeing a happy or neutral face. These findings indicate that there may be an association between valenced faces and vertical selective attention that is consistent with orientational metaphors (positive = up), but further research is needed to clarify this.

University of Waikato

Pevreal, Jenny (PhD, 2012)

Title: The Science Of Meditation: From Mysticism To Mainstream Western Psychology

Chief Supervisor: Dr Jo Thakker, Supervisor: Dr Judith MacDonald

Psychological applications of meditative practice have become the 'third wave' tools in the psychology clinician's therapeutic tool kit. Meditation techniques for numerous psychological disorders, as well as the psychological impacts of chronic medical conditions, are being used by a growing number of mainstream clinicians in Western healthcare contexts, which were previously the domain of alternative practitioners, and formerly the sometimes secretive and mysterious domain of the orthodox and esoteric spiritual traditions. Many questions arise regarding how this conversion has taken place and why.

This thesis explores some of the issues surrounding the adoption, reduction, and application of meditation practices from its Eastern and Western origins and transmission to mainstream Western healthcare contexts. By tracing the history of the rise in popularity of meditation in the mainstream Western health sciences,

particularly within the mental health sector over the past century or so, it is intended to contribute to an answer to, in part, the question of 'why' and, in part, the question of 'how'.

A further question of whether sufficient cognizance has been taken of the subjective experiences and understandings of long-term meditation practitioners and what they can contribute to Western psychological understanding of meditation – its application potentials and pitfalls – is explored. Why is this important? At present, being intelligent, and highly trained, as most clinicians have come to believe they are, it has become somewhat taken for granted that reading journal articles or books on meditation, and attending a workshop or two, perhaps even a week-long residential training retreat, qualifies one to begin using meditation processes with clients. However, is clinician training and competency in the use of meditation currently sufficient to ensure the safe and appropriate use of meditation, particularly for psychologically impaired clients, given the phenomena reported by long-term meditators and the judicious preparatory processes required by teachers in the wisdom traditions of origin?

Mary Clark, MSocSc, 2012,

Title: Relaxation/Stress Management Intervention With Women With Pregnancy Stress Anxiety

Dr Carrie Barber (Chief Supervisor, Dr Nicola Starkey

Pregnancy is a time of change that has the potential to be a stressful experience for some women. There is evidence from animal and human studies that long-term exposure to maternal stress can be detrimental to the unborn baby, both before and after birth. Non-pharmacological interventions that are aimed at assisting pregnant women to mediate the way they respond to stress are particularly relevant for the pregnant population, due to the potential teratogenic risks associated with drug therapy. Mindfulness-based therapies have the potential to be beneficial for pregnant women. The aim of this study was to explore the effect of a brief biofeedback-assisted mindfulness meditation procedure on the physiological responses of pregnant women and their babies. Six women in the last trimester of pregnancy completed a brief mindfulness meditation procedure. Each participant's physiological responses

(heart rate, respiration rate and galvanic skin response), and her baby's heart rate, were measured across baseline, teaching and practice conditions. The results indicated that the procedure was associated with a physiological change in at least one of the variables for all of the participants. The procedure was not, however, associated with a change in all of the variables for any of the participants. The procedure was associated with a decrease in the mean fetal heart rate in four of the six babies. There was no clear association between maternal physiological responses and fetal responses for five of the six participants. The findings suggest that biofeedback is helpful in assisting participants to learn and practice a brief mindfulness meditation procedure.

Melanie Haeata, MSocSc, 2011,
Title: Anxiety, Stress And Depression
During Pregnancy: Correspondence
Between Partners

Dr Carrie Barber (Chief supervisor), Dr Nicola Starkey

Anxiety and depression throughout the antenatal period are associated with a multitude of adverse consequences. To date, little research has been conducted with both mothers and partners during the antenatal period particularly within a New Zealand context. The aims of this study were to identify rates of elevated anxiety and depression among antenatal mothers and partners, gain a clearer understanding of the relationship between anxiety and depression within couples and to examine risk factors for antenatal anxiety and depression. 57 couples, half recruited from the community and half from an antenatal inpatient unit, completed the PSAS, STAI, and EPDS. Results indicated that mothers and partners had almost identical rates of state (29.1% and 27.8% respectively) and trait anxiety (20.0% and 20.4%) and co-morbid anxiety and depression (10.5% for each gender). Furthermore, mothers experienced on average significantly higher trait anxiety and depression than partners. All measures were significantly correlated as were couples' anxiety and depression. Although not significant on their own, risk factors for mothers' anxiety and depression included pregnancy complications, low income level, belonging to an ethnic minority and young age. Partners' risk factors for anxiety included belonging to an ethnic minority, low level

of education and earlier stages of gestation. Only ethnicity was a significant risk factor for state anxiety after controlling for the others. Implications of this research are discussed.

Lily de Bruin, MSocSc, 2011,
Title: Who Would Young People
Seek Help From For Particular
Psychological Problems And Why Do
They Prefer Particular Options More
Than Others?

Assoc Prof Doug Boer (Chief Supervisor), Dr John Fitzgerald

This thesis explored the help seeking of adolescents. In particular it focused on who adolescents seek help from for particular problems, the relationship between the options they selected, gender, previous help seeking and psychological distress, their experiences of seeking help for themselves, providing advice to friends and their opinions of help seeking for adolescents. One hundred and forty three adolescents between the ages of 15 and 18 who were attending two high schools in Hamilton, New Zealand, completed a Help Seeking questionnaire and the Youth Outcomes Questionnaire-30.2 (YOQ-30.2). Seven participants completed a semi structured interview focusing on their experience of seeking help. The results indicated that friends followed by parents were the help sources that were endorsed most frequently overall. Informal sources of help were selected more often than formal options. Of particular interest was the frequency with which 'no one' was selected as a first choice option. Males' YOQ-30.2 total scores were significantly higher compared to females. Females were significantly more likely to have sought professional help in the past. Significant relationships were found between the help seeking options selected for the respective questions and gender and previous help seeking from a professional. Key themes that emerged from the semi structured interviews included increasing awareness of help options, the helpfulness, trustworthiness and friendliness of help sources, closeness of the relationship, what adolescents have heard about the help source, and the reaction of the help source when being informed about the young person's difficulties. Males appeared to be more likely to encourage their friends to seek professional help and to feel confident in providing help to a peer. The implications of these findings were discussed

in relation to the current literature.

Sarah Campbell, MSocSc, 2011,
Title: The Experiences Of Youth Gang
Members In South Auckland

Dr Jo Thakker (Chief supervisor), Assoc Prof Doug Boer

The purpose of this study was to understand the experiences of young people who were actively engaged in youth gangs. This included developing an understanding of the factors that both influenced and maintained their desire for youth gang membership. This was achieved by carrying out seven semi-structured interviews with young people aged between sixteen and twentythree who were residing in the city of Hamilton, New Zealand. The interviews were recorded and transcribed verbatim to ensure the experiences of these young people were accurately recorded. A thematic analysis of the data was then carried out, highlighting both the themes and subthemes across the data set.

Five primary themes were identified within this data set to highlight the factors that both influenced and maintained a desire for youth gang membership. This included the influence of friends, the availability of money, and a desire to participate in antisocial behaviours within the gang. Participants also explained the importance of their neighbourhood surroundings in facilitating youth gang membership. While these overarching themes have been previously reported within literature (Goldstein, 1991; Thornberry, Krohn, Lizotte, Smith & Tobin, 2003), the young people in this study offered their subtly unique experiences and journey into the gang lifestyle. The final theme highlighted the negative evaluation that these young people perceived to experience from others which influenced and maintained their desire to pursue the gang lifestyle. This finding is not as prevalent in the existing youth gang literature, but is discussed within the social psychology literature as the "self-fulfilling prophecy".

One of the main findings of this study was that these young people were engaged in the youth gang lifestyle from as young as nine years of age. Once accepted into the gang, participants explained that they then began to withdraw from school and other mainstream activities to pursue their life in the gang. It then became difficult to present these young people with an alternative

to their chosen lifestyle as they had access to the support, tangible goods and respect that was desired. They were also accepted into a group of like-minded friends who existed as a substitute family. Further research is needed to better understand the variety of experiences that young people in New Zealand have when joining a youth gang.

Marie Townsend, MSocSc, 2011,

Title: Māori Conceptualisations Of Dementia

Assoc Prof Doug Boer (Chief Supervisor), Dr Tess Moeke-Maxwell

E iti noa ana, na te aroha

(It is the giving that counts and not the size of the gift)

The purpose of this thesis was to investigate the perceptions of Māori health professionals about Māori elders and dementia. The study aimed to describe: Māori health care providers' understandings of dementia; traditional versus contemporary understandings; how cultural beliefs affect experience; how Māori cope with dementia; key issues relevant to Māori people with dementia; and how services can be improved to meet the needs of aged Māori. The usefulness and possible cultural adaptation of the biomedical model has been explored within the context of a Māori worldview and the perceptions of participants. Semi-structured and in-depth interviews were conducted with eight mental health professionals and one caregiver. The information gathered at interviews was recorded within verbatim transcripts, which were written and returned to the participants for feedback. A qualitative data analysis was carried out on the approved transcripts.

The main findings suggest that Māori health professionals recognise that many Māori perceive dementia both from a traditional cultural perspective, associated with spirituality as well as a holistic understanding of wellness. Key issues identified by participants were: that there is fear associated with mental health facilities; the exclusion of cultural values and understandings from service providers is detrimental to the wellbeing of Māori elders; Māori do not understand the symptoms typically associated with dementia as an illness; there is a need for information and education within an appropriate frame for whanau; disjointed and multiple service providers inhibits Māori from accessing facilities offered; and that there is a real need for further services. It was considered important that mental health services are culturally appropriate, show respect for Māori values; are coordinated and sensitive; encourage and continue the development of a Māori mental health workforce; and further develop kaupapa Māori services for Māori elders.

The main implication of this research is that further investigation into Māori and dementia is required. Recommendations are made with a view towards better addressing some of the mental health needs of Māori elders.

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An Interview with Janet Holmes



Professor Janet Holmes holds a personal Chair in Linguistics at Victoria University of Wellington. She teaches sociolinguistics courses, specialising in workplace discourse, New Zealand English, and language and gender. She is Director of the Wellington Language in the Workplace (LWP) project and a Fellow of the Royal Society of New Zealand. Her books include *Gendered Talk at Work*, *An Introduction to Sociolinguistics*, now in its third edition, and the Blackwell *Handbook of Language and Gender* (co-edited with Miriam Meyerhoff). With her colleagues in the Language in the Workplace project, she has also published on leadership

discourse, humour, and the relevance of gender and ethnicity in the workplace. Most recently, together with Meredith Marra and Bernadette Vine, she has authored a book *Leadership, Discourse, and Ethnicity* (OUP), which examines effective leadership in Māori and Pākehā organisations.

Your area of expertise is sociolinguistics- can you describe what this field encompasses?

Sociolinguistics is the study of the relationship between language and society. This is a very broad area: it encompasses the study of how people communicate in different contexts, both monolingual and multilingual, how people switch languages and/or styles according to who they are talking to, and how they develop ways of talking which characterize their in-groups. Sociolinguists are also concerned about language policy issues: which languages are most appropriate as national and official languages, for example? How can we revitalize dying languages? Why do communities shift to a new language? Other issues of interest include gender and ethnic differences in the use of language: why do women tend to lead language change? What are the features of Māori English? What are the characteristics of polite language in different cultures and contexts? These are all issues of interest to a sociolinguist.

What prompted your interest in studying language in the workplace?

I had been studying New Zealand English and I wanted to make a contribution which was socially useful. No-one in New Zealand had considered how we talk at work and it struck me that newcomers to New Zealand might find that ways of talking in different workplaces were unfamiliar or challenging. So it seemed a very interesting area that offered the possibility of useful applications for new employees and for immigrants to New Zealand. I began the Language in the Workplace Project in 1996 with FRST funding focusing on what makes for successful communication at work and what causes miscommunication. Since

then we have had many other sources of funding including a generous Marsden grant which enabled us to study ways of communicating in distinctively Māori workplaces.

What specifically did you study and how did you carry out your research?

We are interested in the way people talk to each other in a range of contexts at work.

We have studied many different aspects of workplace talk, including small talk, humour, the way people get others to do things (directives), the way people open, close, and manage the agenda in meetings, how decisions are made, and how problems are solved. We have also studied similarities and differences in leadership styles and in the way senior women and men talk at work, as well as the distinctive features of Māori workplaces.

Our methodology is based on two principles: (i) identifying issues of interest to both the organisations and the researchers; and (ii) building strong relationships with volunteers in organisations. Perhaps the most distinctive feature of our approach is that we ask the participants themselves to record their talk and we stay as much out of sight as possible. We give people a recording device to carry around and ask them to record about four hours of their everyday work talk over a period of a week. To record workplace meetings, we set up our video cameras in the meeting room before anyone arrives, and then disappear till after the meetings are over. Essentially we try to be invisible around the workplace while our participants cooperatively collect our data. Our follow-up interviews are

designed to be well-focussed and brief, in order to intrude as little as possible on the time of our participants. This method was very successful in white collar, majority group workplaces. It needed some adaptation, for blue collar workplaces such as noisy factories and building sites with very mobile workers, and also for working in Māori workplaces, where we were expected to be around and much more available to discuss what we were doing. (For more discussion of this point, see chapter 2 of our book, *Leadership, Discourse, and Ethnicity*).

What were some of your main findings- was anything particularly surprising?

There are a number of helpful features. Our results suggest that there are no simple rules for effective communication.

For example:

- The most direct and explicit way of getting a message across is not necessarily the most effective. Context is always crucial and the aspects of context which are relevant may be very subtle.
- Humour and small talk play an important part in smooth workplace communication. There are many different styles of humour and some workplaces can be differentiated by their preferred style of humour.
- Repetition and “recycling” of ideas and information is common in meetings, and assists in conveying information, decision-making and problem-solving.
- Skilled communicators use a variety of strategies - they adjust their language and methods of communication according to who they are talking with and what they are talking about.

- Māori workplaces (with Māori values and a commitment to achieving goals of benefit to Māori) tend to have distinctive ways of interacting including ways of running meetings and giving feedback.

What responses have you had nationally and internationally to your language in the work place research?

We have had a very positive response both nationally and internationally. People in New Zealand are very interested in our findings and they have been applied in courses which focus on communication in the workplace.

Internationally our work has been widely published in respected journals and I have had invitations to speak at international conferences all over the world. Our methodology has also been regarded as very useful and many other researchers have adopted our way of collecting and analyzing data.

Has your research led to any changes being made in specific workplaces as far as you are aware?

Managers report finding our descriptions of meeting management styles useful for reflecting on their own styles. Some report that they have changed their ways of running meetings as a result.

Those teaching workplace communication courses find our results very valuable for preparing people for the ways of doing things in New Zealand workplaces which in some areas are very different from those of Asian and European workplaces. More specifically, in one of the factories where we collected data, one of the outputs was a training video which was subsequently used for communications skills training. And in one of the commercial organisations,

a Communication Evaluation Development programme was run as a follow-up to our research. This is described in Chapter 8 of our book *Power and Politeness in the Workplace*.

Ways of welcoming new staff to the workplace have been influenced through the work of the consultants and staff on the Victoria University Workplace Communications Skills course.

In one of the Māori workplaces, the participants were inspired to initiate some further research on the basis of our work with them. We provided methodology training workshops for their staff.

Overall our research has a number of practical applications in the workplace:

- Management and communication skills training
- Communication evaluation and development
- Mediation and conflict resolution
- Training resource materials
- Supported employment
- Communication skills for workers from non-English speaking backgrounds

Are there aspects of your research that you think might be of particular interest to psychologists?

In general, participants report a much heightened awareness of communication strategies and skills. Some employers have begun to draw their staff's attention to the applied material we produce in order to assist them to help newcomers settle in better. More specifically, the Settlement Division of the Department of Labour has worked with us to develop informative materials for their website for employers. These are aimed at providing information which will

influence attitudes to immigrants in particular.

We have produced a good deal of material on intercultural interaction in which we have focused on different norms of interaction and different expectations which can affect the success of an interaction. Our research identifies some of the sociolinguistic strategies that people use to create in-groups and out-groups e.g. humour, small talk, in-group jargon

Finally, our research provides very interesting sociolinguistic evidence of the tall poppy syndrome in New Zealand workplaces, along with the high value placed on humility or whakaiti in Māori workplaces. Though these have different roots, the linguistic manifestations are often similar.

How can people access your research findings?

We have a website: **www.victoria.ac.nz/lals/lwp**

We have published a number of books and we have published a long list of papers many of which can be found on the website or are listed on my webpage.

One on One - with Erana Cooper

Dr Erana Cooper was invited as our 'one on one' contributor.



One aspect of your role that you find really satisfying

I have the privilege of being involved in a really wide range of activities in my role/s, which means I have the opportunity to work alongside some fantastic colleagues, students, practitioners and whānau. These connections are hugely important to making my work as enjoyable and rewarding as it is. I learn new things every day and I hope this never stops. I get to see 'the power of the collective' in action in a lot that I'm involved in – there is something so great about that!

One event that changed the course of your career

I was 17 when I started university and the first person in my family to attend. Accordingly I didn't really know what I was doing and had a first year subjects list that looked like a smorgasbord (this was back in the day when you could 'try out' papers in your first year and not have to be too focused). Unfortunately as a result I was really bored most of the time. However,

I was not bored with playing pool at the UniClub (basically a drinking establishment for students that doesn't even exist anymore) and subsequently became the UniClub Female Pool Champion of the Year! My parents weren't too happy about that and thought that being a Champion at Passing My Papers would have been much better. After that year I had to get special permission from the now famous Professors Michael Corballis and Michael Davison (the ingoing and outgoing Heads of Department at the time) to continue studying in psychology! They gave a young girl a second chance and at the time I made a bold promise to myself that I could get four degrees (as well as have a family) by the time I was 40. I just made the cut at 39 – so thank you Profs! I'm not sure if I would have ever been so focused if I hadn't had that crazy year and set such an outrageous goal.

One alternative career path you might have chosen

I have a really strong interest in the law so can't really understand why everyone looks at me strangely and refuses to engage when I start talking about how I might take up a law degree one day (well, we'll need more psychologist lawyers in the future won't we??!!). I think I'm still working on letting this go ...

One learning experience that made a big difference to you

Many years ago when I was learning about how to be a clinical psychologist I was worried about what to do when faced with clients who had experienced great loss, who were bereft and full of grief (I had this horror image of myself just sitting there not knowing what to do or say). When I asked one of my

mentors about it, she said “Erana, hold on to your heart”. “If you do nothing else, you might be the first one, or the only one, to bear witness to their pain. That alone is a lot to do”. She had a lot of ideas to share about other things to say or do, but that struck me deeply and profoundly, and reminded me that our practice as clinical psychologists is really all about human connection.

One book that you think all psychologists should read

Pedagogy of the Oppressed by Paulo Freire. I'd also recommend *Preventing Violence* by James Gilligan and *The Gift of Therapy* by Irvin Yalom. I don't think I've ever felt as many different emotions in such a short timeframe as I did when I read the book *The Boy in the Striped Pyjamas* by John Boyne (you may have seen the movie).

One challenge that you think psychology faces

Successfully entrenching cultural competence (and on-going development in it) into research, teaching, training, and the practice of psychology, as a priority, in a genuine, meaningful way.

One thing that psychology has achieved

Big 'leaps and bounds' in relation to the above over recent years. However, there remains a lot of work to be done in terms of on-going workforce professional development and capacity building, structural support, and still some resistance to be eroded.

One aspiration for New Zealand psychology

To develop more 'Aotearoa-New Zealand Psychology' – a psychology that has strong local relevance. We (all of us here) have a lot to offer in many areas of teaching, research, and practice knowledge or expertise – and we have a strong, continuously

growing indigenous base that can contribute towards a unique New Zealand view of psychology and how it is applied here. No one else in the world can do this except us all here! 'Local psychology' can also contribute to world-wide developments in psychology. In our ever increasing global world I think this is an important aspiration.

One social justice issue psychology should focus on

Inequity. One of the most powerful quotes I read recently was from the World Health Organization's Commission on Social Determinants of Health, which was that “Reducing health inequities is ... an ethical imperative. Social injustice is killing people on a grand scale” (2008, ii). [yes, I had that at hand]. I think we can do a lot of good work as psychologists, but it can be seriously undermined if we don't address the broader issues contributing to inequity in our communities. Health (and other) inequities have a huge impact on Māori in Aotearoa – but it doesn't need to be that way. We can all play a role in advocating for a more 'just' society in all the various work that we do as teachers, researchers, and practicing psychologists.

One big question

What kind of world do I want my mokopuna to inherit?

One regret

It's not really a regret, but sometimes I wonder what life would've been like if I hadn't inherited the family curse of not being able to say 'No' (!)

One proud moment

When I looked at my four sons, my husband, and my mum and dad, and spoke to my sister and brother on the day of my PhD graduation - we'd been having a long, tough run with illnesses

in the whānau and demands aplenty (let alone finishing the thesis) but it was done and we had survived and were all around to celebrate!!

One thing you would change about psychology

I'd like us to be more 'together' (as in the different fields of psychology), or at least to create more opportunities to come together in a way where things don't have to be too complex. I think sometimes the structures around us can inhibit our freedom, and while there are so many great things about the uniqueness each particular area brings, there is also a huge amount to be gained from coming together where we can. This may be partly motivated by the fact that when someone asks me what my broader interests in psychology are, and I answer with 'critical indigenous clinical community psychology' – they just look so perplexed!

One piece of advice for aspiring psychologists

Live, love and laugh (actually that might have been for everyone not just aspiring psychologists). Open your heart as well as your mind (ok that was for aspiring psychologists). Follow your bliss. Be involved with the people around you and trust in the collective. Kia kaha, kia maia, kia manawanui!



Just one review this time round related to the important topic of treating complex trauma. Many thanks to Jackie Feather, for her review. If you are willing to review or have come across an interesting book that you think would be worth having reviewed please make contact with me via office@psychology.org.nz. John Fitzgerald- Review Editor

Treating complex trauma in adolescents and young adults.

Reviewed by Jackie Feather, PhD. AUT University.

John Briere and Cheryl Lanktree are well known and well respected in New Zealand for their contribution to the trauma treatment literature as well as for their training of local practitioners. John Briere, in particular, has been a regular contributor to local training. The first workshop I attended (in the 1990s) was lead by this formidable couple, and it is Cheryl who has particular expertise in working with young people. This book on treating complex trauma in adolescents and young adults is a welcome addition to the literature. It is immensely readable – for those so inclined, it can be read from cover to cover in a day. It takes us on a journey from assessment through to treatment components,

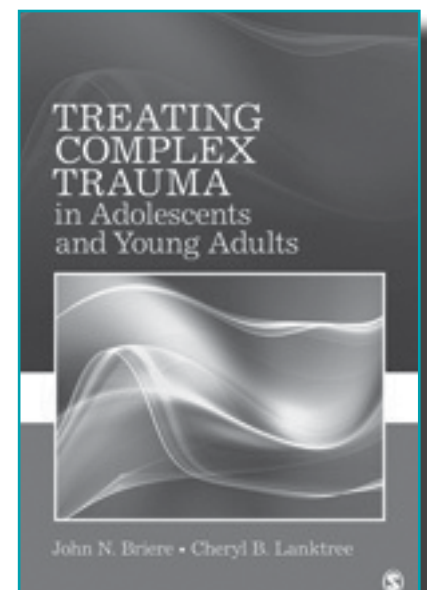
loops through research evidence, and ends nicely with three case examples. The appendices provide supplementary material including assessment guides and therapy task sheets.

While developed in the North American context, the description of the range of causes and sequelae of complex trauma experienced by young people differs little from what we might be working with in New Zealand. The authors make the point that while complex trauma is more likely to be experienced by disadvantaged young people, violence and abuse are found at all socioeconomic levels, by both genders and in all cultural and ethnic groups. As such, their approach is imminently applicable in the New Zealand context where we are working across the spectrum from the extremes of child abuse, neglect, and interpersonal violence, sexual exploitation through prostitution, trauma associated with refugee status, to middle class young people profoundly affected by events that occurred as a result of a potent mix of drugs, alcohol and sex, precipitating a cascade of complex trauma reactions – unfortunately an experience all too commonly reported.

The approach is multimodal and multicomponent. It is assessment-driven, with an emphasis on evaluating and ameliorating the cycle of environmental risk, self-endangerment and the ongoing effects of trauma. A comprehensive assessment model is presented, and this is clearly linked to the treatment components. The treatment model is integrative, but by no means eclectic. It is a well thought-out step-by-step approach based on clinical experience and research that draws on psychodynamic understandings, cognitive behavioural therapy, family systems theory, and trauma and abuse models and practice. The paradigmatic inclusiveness is

seamless and practice focused, with the therapeutic needs of the young person put front and centre.

The treatment components are presented in chapters, comprising the expected order and emphasis on relationship building and support, safety, psychoeducation, emotional and cognitive coping strategies, titrated exposure and caregiver interventions. In addition, there are chapters specifically devoted to trigger identification and intervention, relational processing and interventions for identity issues, essential elements to address when treating complex trauma. The inclusion of a chapter on family therapy will be a welcome addition for therapists working with adolescents whose recovery is compromised by family dynamics and conflicts. A chapter on group sessions provides an adaptation that I can imagine being put to good use in residential settings. The content and length of each chapter is about right, and additional references are provided for therapists who may require more detailed information about particular treatment elements.



There was little to criticize about this book. Personally, I found the use of

an acronym (ITCT-A) to describe the approach somewhat annoying, a small point but a simple catchy name can be useful when working with adolescents. I would also be wary about setting adolescents trauma processing tasks for homework, I prefer to contain these within session so that trauma responses can be monitored and addressed. With family interventions, there could perhaps have been more guidance about the involvement of younger children in trauma processing activities.

In summary, this is a comprehensive, clinically valid, culturally sensitive treatment approach that has good initial empirical evidence. One feeling I was left with after reading this book was a sense of validation for the work we do in this area in New Zealand. While we have no doubt benefited from the international literature and direct training opportunities from the likes of John Briere and Cheryl Lanktree, we have embraced this material and integrated it into our own local practice, within a cultural worldview unique to our country. Having said that, this book provides a synthesis of up to date practice in the field and it will be a valuable addition to the “kete” for anyone working therapeutically with traumatised abused adolescents and young adults, whether a seasoned practitioner or new to this most important work.

Treating complex trauma in adolescents and young adults.
John N. Briere & Cheryl B. Lanktree (2012).
Thousand Oaks, CA: Sage Publications, Inc.
Review copy supplied by Footprint Books

Editorial



Rosalind Case
Student Forum Editor

In our last issue, which went to print way back in April, I was having to write about the then-upcoming NZPsS and NZCC Annual Conference as if it had already happened. I gave the game away pretty quickly when I admitted that we didn't actually know who had won the student prizes yet. I also took a massive risk by making a pre-conference joke about conference food, with an overstated allusion to honeydew melon as the staple diet of conference-goers around the world. This led to weeks of panic in which I wondered had I jumped the gun? What if this was the one conference in the history of the universe where there was no honeydew melon? What would people say? Would my academic career fall flat, just like that? Imagine my relief, then, when we arrived in Wellington to find that, indeed, honeydew melon was on the menu. My joke that probably nobody read was saved and my fledgling career is not yet destroyed, with opportunities for future embarrassment still abounding. So that's great news. Now that the conference has been and gone and my melon-anxiety

is significantly reduced, I also now have the pleasure of congratulating a number of our student presenters. The calibre of presentations this year was very high and our student winners can be proud of themselves for standing out amongst an already very impressive group.

We would like to offer our sincere congratulations to our three student winners, Maria Polak (University of Otago), Sarah Campbell (University of Waikato) and Kiri Luther (Massey University). Maria Polak was awarded a \$150 book voucher for her poster titled *Association of vitamin D status and depression scores in a non-clinical sample*. Sarah Campbell was the winner of the Institute of Clinical Psychology Best Student Conference Paper prize with her presentation *Youth Gang Membership: Factors influencing and maintaining membership*.

Sarah received a cheque of \$250 from the Institute. And finally, Kiri Luther's presentation *Long Term Cognitive Outcomes of ECT: Quantitative and Qualitative Perspectives* won the NZPsS Best Student Conference Paper. Kiri received a book voucher for \$250.

Which leads us to the current issue of *Psychology Aotearoa* and the *Student Forum* section. We are pleased to be able to reproduce Maria Polak's poster presentation in this edition. Additionally, Kiri Luther's winning conference presentation is elaborated on in her article of the same title. Her research uses interpretative phenomenological analysis (IPA) to examine patients' subjective experiences of electro-convulsive therapy (ECT) along with their perceptions of their memory and cognition post-ECT. The qualitative methodology that Kiri has employed is not often used in the assessment of neuropsychological outcomes and she

has yielded some rich and enlightening results. Other submissions in this issue include Kirsty Fraser's review of the literature related to thought-action fusion and its relationship to psychopathology, and Tess Chalmer's exploration of client change in Waikeria Prison's Maori Focus Unit, Te Ao Marama. It's exciting to have such a wide variety of articles to include in this issue's *Student Forum* and I believe that there's a lot to be gained for both students and practitioners from engaging with these burgeoning research areas.

We have recently been considering ways in which we can assist our student readership in the decision-making that many must make at graduate level in relation to future study programmes and pathways. As government financial (and, arguably, moral) support for students in specialised and extended study programmes such as clinical psychology declines, it seems it has never been so important for students to make clear and considered choices around graduate study. Gone are the days where one could afford to drift in to a programme of study and then decide halfway through that "perhaps this isn't really for me". However, making career pathway decisions can be made difficult by a lack of information regarding options. Often we are limited by what is on offer at the university in which we have completed our undergraduate degrees, not realising perhaps that some universities offer programmes and options that others do not. Indeed, some students may be interested to learn that registration options exist outside of a university context. There is great variation in what is available and so it seems timely that we start to pull this information together for our readers so that students are able to compare and contrast what is on

offer around the country and make considered decisions about their next step.

With this in mind, we are pleased to include in this issue a contribution from Glen Kilgour of the Department of Corrections regarding the Supervision to Registration scheme. Glen is very experienced in the area of student supervision and we are grateful to him for providing students with this information. Those with an interest in correctional psychology and considering a postgraduate programme of study may be particularly interested to learn more about this scheme.

And so that concludes 2012. There is still a whole month to go until the world is supposed to end altogether so if you are interested in submitting a piece of your own writing for our next issue, particularly as it relates to psychology research or practice, I'd love to hear from you in the meantime at rcase@waikato.ac.nz. If it turns out that the world does still exist after December 21st 2012 then apparently our next deadline for peer-reviewed articles is March 1st 2013 and for all other student forum pieces, April 1st 2013. In the meantime, I would like to wish you all a wonderful holiday season and a restful, rejuvenating (Armageddon-free) summer.



Maria Polak is currently doing her PhD in the Daily Experiences Lab at Otago with Dr. Conner. She is passionate about wellbeing.

Her best conference student poster (see opposite page) is titled: *Association of vitamin D status and depression scores in a non-clinical sample*

Association between vitamin D status and depression scores in a non-clinical sample

Maria Polak¹, BSc(Hons), Lisa Houghton², Ph.D., and Tamlin Conner¹, Ph.D.

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Introduction

Vitamin D and mental health

Recently, there has been an increased interest in the potential role of vitamin D in mental health and wellbeing. Vitamin D is a lipid-soluble vitamin manufactured in response to sun exposure or, to a lesser degree, obtained from food. In addition to the well-appreciated role in the metabolism of calcium, vitamin D may also play a role in mood regulation. Vitamin D receptors are present in numerous different types of cells, including neurons and glial cells. Most importantly, vitamin D is now accepted for its neurosteroid activity and impact on brain serotonin. There is some evidence that low circulating level of serum 25-hydroxyvitamin D (25(OH)D), the marker for vitamin D status, is associated with mood disorders, including major depressive disorder, seasonal affective disorder, and premenstrual syndrome. Serum 25(OH)D levels decrease over winter, potentially increasing the incidence of these disorders. At the same time, suboptimal vitamin D status is increasingly common in Western countries. Vitamin D has recently gained popularity as a 'mood elevator' and is widely taken in supplemental form by the general population.

Other factors related to vitamin D production have been proposed to have a similar connection with depression, namely natural light and physical activity. Thus, time spent outdoors during daylight hours or the amount of physical exercise could be potential moderators of the association between vitamin D status and depression.

Aim of current study

We investigated the association between vitamin D status and depression scores in a non-clinical sample of young adults, taking into account time spent outdoors and physical activity. We hypothesised that vitamin D status would be associated with depression scores, but this association would no longer be significant when accounting for time spent outdoors and physical activity.

Acknowledgements

We thank all participating students for taking part. The Daily Life Study was funded by a University of Otago Research Grant to Tamlin Conner. The authors also gratefully acknowledge the entire Daily Experiences Lab team and the assistance of Haoyi Youens for web programming.

Methods

Participants

Participants were 315 University of Otago students [200 women (63.5%) and 115 men (36.5%), mean age 19.8 years] who took part in the Daily Life Study, a study of daily student experiences and biological markers of wellbeing, during the 2011 academic year.

Measures

- ✓ Demographics including age, gender, and ethnicity
- ✓ Computerised version of the Centre for Epidemiologic Studies Depression Scale (CES-D) completed on day 1 of the study.
- ✓ A 13-day diary, in which participants reported on
 - time spent outside during daylight hours (12 categories ranging from 0 = none to 11 = 10 hours per day)
 - amount of moderate and vigorous exercise (in minutes)
- ✓ Venous blood sample for 25(OH)D analysis on day 15 of the study.

Analysis

Firstly we reverse coded the relevant CES-D items and computed a total score for each participant. Then we calculated a total score for time spent outdoors during daylight hours and the average time spent per day in moderate or vigorous exercise for each participant. Serum 25(OH)D was analysed using the isotope-dilution liquid chromatography tandem mass spectrometry method. We performed a regression analysis to examine the relationship between vitamin D status and depression taking into account gender, age, and ethnic background. Finally, we added time spent outdoors and physical activity as control variables.

Results

- ❖ Total CES-D scores ranged from 0 to 41 (M=13.4, SD=8.3). A score of ≥ 16 is the cut-off for clinical depression.
- ❖ Participants' weekly scores for time spent outdoors ranged from 2 to 40
- ❖ On average, they spent 35 minutes per day doing moderate or vigorous physical activity (range 0 to 177 minutes).
- ❖ Serum 25(OH)D ranged from 8.2 nmol/L to 177.0 nmol/L (M=62.7, SD=26.4)

Vitamin D status was significantly negatively associated with the depression scores (controlling for gender, age, and ethnicity) ($B=-.208$, $t=-3.461$, $p<0.001$). This relationship remained significant even after adjusting for time spent outdoors and physical activity ($p=.003$). Every one SD increase in serum 25(OH)D was associated with a 5 point decrease in the CES-D score on average (Figure 1).

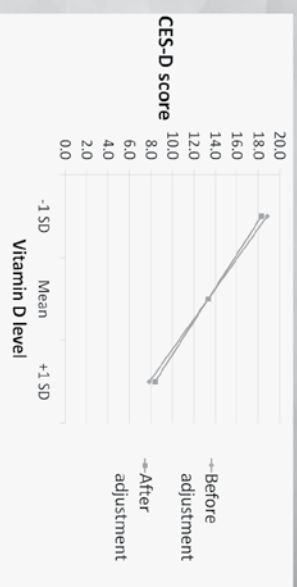


Figure 1. Relationship between vitamin D status and depression score before and after adjustment for time spent outdoors and physical activity

Summary

- ❖ Vitamin D status was significantly negatively correlated with depression scores in this young adult sample.
- ❖ The association between vitamin D status and depression scores remained significant even after taking into account time spent outdoors during daylight hours and amount of physical activity.
- ❖ These findings suggest an opportunity to investigate supplementation with vitamin D at sub-clinical levels of depression.



Exploring Client Change in Waikeria Prison's Māori Focus Unit (MFU): Te Ao Marama

Tess Chalmers, Massey University, Auckland

Mei Wah M. Williams, Massey University, Auckland

Jhanitra Gavala, Massey University, Auckland



Tess Chalmers was awarded the Karahipi Tumuaki, President's Scholarship in 2011. Tess is of Te Arawa descent, Ngāti Whakaue Hapu, and is from the Bay of Plenty. She is currently in her second year of the Doctor of Clinical Psychology programme at Massey University, Auckland, and has the future desire to work within the Department of Corrections. The research she is currently conducting reflects this future ambition, as it attempts to explore client change within Waikeria Prison's Māori Focus Unit, Te Ao Marama. Her paper provides the background rational of the study, and introduces the research process. Tess hopes to write a further paper discussing the results, on completion of the study

The Ministry of Justice (2009) continually reports an over-representation of Māori within the incarcerated population. An attempt to address these concerns led to the development of the Māori Focus Unit (MFU). At present there are limited studies informing the relationship between MFU participation, Māori identity and offender change. The current research based at Waikeria Prison's MFU- Te Ao Marama, attempts to identify the relationship between MFU participation and Māori identity through qualitative enquiry, and then explores whether changes in Māori identity relate to changes in anti-social cognitions, and anti-social behaviour predictive of recidivism, through quantitative measures. This paper will introduce the study and research process.

There is not one type of offender, one cause for offending, or one intervention effective for all offenders. Consistent across the forensic literature, is the disproportionate level of offending by minority groups

(Beacroft, 2009; Fergusson, Horwood, & Lynskey, 1993; Phinney, 1990). One theory that accounts for the high level of offending in these groups stems from social identity theory, suggesting that a positive ethnic identity contributes to higher levels of self-esteem and well-being, which then reduce the likelihood of anti-social cognitions and externalising problem behaviour (Phinney, 1990; Wissink, Dekovic', Yagmur, Stams, & Haan, 2008). In accordance with this theory, when minority groups are unable to obtain a positive identity, due to assimilation and colonisation, anti-social patterns are more likely to persist (Wissink et al., 2008). Furthermore, it is argued that traditional indigenous values obtained from a strong cultural identity conflict with anti-social patterns (Sanchez-Way & Johnson, 2000).

Multiple studies have indicated a link between different aspects of ethnic identity and problem behaviour. Arbona and colleagues (1999) found that a lack of positive ethnic identity emerged as a predictor of African-

American adolescents' attitudes toward fighting. Marsiglia and researchers (2004) found that minority ethnicities living in America who reported strong ethnic affiliation, attachment, and pride had less narcotic use, and stronger antidrug associations. In Korean-Americans, Lee (2004) found that a positive ethnic identity served as a moderator to problem behaviour, and Wissink and colleagues (2008) demonstrated that for Moroccan-Dutch adolescents living in the Netherlands, stronger ethnic identity was related to a lower level of problem behaviour. Marcell (1994) argued that a lack of positive ethnic identity may contribute to problem behaviours in Mexican-Americans, and finally Brook and colleagues (1998) reported that a strong sense of ethnic identity may protect adolescents from engaging in delinquent behaviours. These studies all propose that achieved ethnic identity may reduce the risk of anti-social behaviour.

Māori offenders

According to the New Zealand census,

Māori made up 14.6 % of the New Zealand population in 2008 (Statistics New Zealand, 2009). In the same year, the Ministry of Justice (2009) released a report indicating that 50.8% of the incarcerated population identified as Māori (Weatherall, Wilson, Harper & McDowall, 2007). Re-offending statistics presented by the Department of Corrections (DOC; 2009) indicated that Māori offenders made up 55% of the re-imprisonment statistics, a considerably higher rate than any other ethnicity. The over-representation of Māori is not new, nor does it appear to be changing (Durie, 1999). In successive prison censuses since 1987, Māori have been disproportionately represented in inmate numbers (Durie, 1999).

In successive prison censuses since 1987, Māori have been disproportionately represented in inmate numbers

Following the signing of the Treaty of Waitangi, the indigenous Māori people were exposed to a progressive process of colonisation which led to an increasing alienation of Māori from their land and their culture (Fergusson, 2003). There seems to be relative consensus that assimilation and colonisation of Māori has resulted in Māori losing aspects of their identity. New Zealand literature identifies a relationship between Māori cultural identity and behaviour (Wikiriwhi, 1998). Jackson's (1988) perspective stems from social identity theory, emphasising the loss of cultural identity as a contributing factor to the high offending rates of Māori. Durie (1998) also proposed a relationship between Māori who have no connection with their identity, and high offending rates, suggesting that when Māori embrace their culture anti-social behaviour

may be minimized. Lawson's (1998) research exploring cultural alienation and negative behaviour in Māori adolescents, suggested a disconnection from one's culture may have "...caused Māori people to act outside of their essential being as Māori...[and to model] ...adverse behavioural responses..." (p.220). Data from the Christchurch Health and Development Longitudinal Study (1977) also projected similar results, with Fergusson and colleagues (1993) arguing a lack of cultural identity as a risk factor for Māori offending, and conversely, a strong sense of Māori identity as a protective factor mitigating against the risk of offending. Furthermore, it is suggested that if interventions are to be effective for Māori offenders, the treatment focus should target the lack of a Māori identity as a risk factor for re-offending, and attempt to build a strong Māori identity, in order to strengthen this as a protective factor (Singh & White, 2000; Hart, O'Toole, Price-Sharps & Shaffer, 2007; Department of Corrections, 2009; Becroft, 2009). Interventions should therefore be rich in cultural components.

Indigenous Programmes

Increasing demand for indigenous programmes to address the disproportionate offending in minority groups have been called for (Fall, 2000; Dept of Corrections, 2009)

... it is suggested that if interventions are to be effective for Māori offenders, the treatment focus should target the lack of a Māori identity as a risk factor for re-offending, and attempt to build a strong Māori identity...

as few programmes exist that are based solely on cultural principles. The few indigenous programmes that do exist have shown positive results. Canadian Indian research exploring

an indigenous Sweat Lodge Ceremony (a sacred purification ceremony) within a forensic psychiatric hospital, found that offenders reported great healing gains from the indigenous ceremony (Fall, 2000). Furthermore, an indigenous programme 'Hollow Water', for Canadian Indian child sex offenders, revealed that only two aboriginal sex offenders, comprising 7% of those who underwent treatment at the programme, had re-offended over a ten year period (Couture, Parker, Couture, & Laboucane, 2001). Research on Asian American populations suggested that when mental health treatment is oriented within the client's cultural view, treatment adherence is increased (Iwamasa, 2003). Similarly, Australian aboriginal mental health research suggested positive results when treatment was in line with an individual's cultural perspective (Nagel, Robinson, Condon & Trauer, 2009).

In New Zealand, the Department of Corrections attempted to address the disparities in Māori offending by integrating tikanga Māori principles within Westernised psychological interventions (Wilson, Tamatea & Riley, 2007). While the therapy was not Kaupapa Māori (created by Māori, for Māori, based on Māori values and principles), it incorporated cultural advisers who assisted with integrating cultural

components into the intervention. However, Durie (2003) suggested that culturally adapted mainstream programmes contradict the values and beliefs which constitute a Māori

philosophy, and the development of culturally specific interventions may be more effective. For Māori, the offender is one who is shaped by his/her distinct culture, which is unique to being Māori (Wikiriwhi, 1998). When interventions are generated from within Māori communities through a Kaupapa Māori approach, Māori experience is placed at the centre of the theoretical base and Māori practices are accepted as the norm (Kingi, Aranui, Tamihana, Crossman & Nuttall, 1991). Durie (1998) proposed that Kaupapa Māori programmes offer an environment endorsing Māori identity resulting in autonomy and self-determination; tenets that are fundamental to basic

When interventions are generated from within Māori communities through a Kaupapa Māori approach, Māori experience is placed at the centre of the theoretical base and Māori practices are accepted as the norm

human rights.

The Māori Focus Unit (MFU)

The MFU is a 60-bed custodial unit operating with a 6 month minimum length of stay and a 24 month maximum length of stay. The MFU acts as a therapeutic community incorporating tikanga and kawa within daily operations in an environment substantiated on a Māori worldview (Department of Corrections, May, 2009).

This includes courses on Māori culture, language lessons, involvement from Māori elders and local iwi members, daily participation in culturally meaningful rituals and ceremonies, and the incorporation of whānau liaison workers within each unit, who support the reintegration of

the offender and assist in the whānau healing process (Ministerial Review Report, 2005).

The fundamental objective of the MFU, which ties into the underlying principles of the DOC, is to reduce recidivism of Māori offenders. The MFU aims to develop the individual and their Māori connectedness through interventions and therapeutic programmes rich in tikanga Māori principles, with the aim of developing a positive identity, leading to an increase in well-being, a decrease in anti-social cognitions and behaviour, and ultimately resulting in a decline of recidivism (Department of Corrections, May, 2009).

In 2009, the Department of Corrections conducted an initial evaluation of the MFU effectiveness. The results from this evaluation indicated that the intervention was producing positive change in the participants, in respect to acquiring tikanga and changing criminal attitudes and beliefs, however, the study was not grounded by any conceptual framework, and there was no exploration of the relationship between an increase in tikanga Māori, a decrease in anti-social cognitions, and participation in the MFU. The study's lack of coherence prompted the Department of Corrections to call for further evaluation.

Current Study

The purpose of the current study is to explore the hypothesis that an increase in Māori identity, through participation in the MFU therapeutic environment, will influence a decrease in anti-social cognitions and behaviour, predictive of future recidivism. The exploration of the relationship between these variables may potentially provide support for the establishment of other therapeutic environments based on tikanga Māori,

as effective intervention models for Māori.

Change will be measured within and across individuals over four data collection periods with six week intervals, through qualitative enquiry, and the following quantitative measures: The Hua Oranga measure (Kingi, 2002) which quantified the four domains of Te Whare Tapa Whā providing a scale for the client, their whānau and a clinician to rate their perception of the client's well-being pre and post intervention, The Cultural Understanding rating from the Multidimensional Model of Māori Identity and Cultural Engagement Revised (Gavala, Hopner, & Gardner, 2011) which provides a rating of cultural understanding prior and post an intervention, Shields and Whitehall's (1991) Pride in Delinquency Scale (PID) measuring identification with criminal others and predicting anti-social behaviour, and Shields and Simourd's (1991)

The exploration of the relationship between these variables may potentially provide support for the establishment of other therapeutic environments based on tikanga Māori, as effective intervention models for Māori.

Criminal Sentiments Scale Modified (CSS-M) measuring anti-social attitudes and predicting recidivism.

Data will be analysed through a Generalised Linear Model (GLM); a combination of regression to calculate monthly improvement and ANOVA to account for differences across subjects (Berridge & Crouchley, 2011). Relationships between variables will be explored through Pearson's product-moment correlation coefficient (Cohen, 1988).

Summary

In recent times, there has been an increased awareness of the effects of assimilation and colonisation on Māori identity, and there has been progression towards promoting Māori to embrace their unique culture through initiatives rich in tikanga (Houkamau & Sibley, 2010). Blackshaw and Walker (2002) propose that any attempts to address Māori disparities across a range of statistics in New Zealand should draw on Māori cultural identity and spirituality. They argue that when interventions for Māori are based on Māori principles, the gaps in disparities can be minimized, and empowerment and self-determination fulfilled. A failure for programmes and services to include a focus on the cultural needs of minority groups may result in a risk of increasing rather than decreasing disparities (Ministry of Health, 2005).

This study will examine the effectiveness of a culturally based therapeutic intervention, in an attempt to address the disproportionate offending statistics for Māori.

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Resilience in New Zealand Psychologists: A Brief Overview

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Katie is a second year clinical psychology student (DCP2) at the University of Auckland. Her interest in the effects of stress and resilience arose following her experiences in the advertising and design industry where she worked as an illustrator. She left her previous profession in 2009 to pursue her interests in psychology however still has part time involvement with the creative industries. Katie plans to complete her internship next year. She aims to incorporate her illustration and creative skill into her new professional roles and in the designing of positive focused interventions.

This paper outlines my current study of resilience in New Zealand psychologists which is part of my Doctor of Clinical Psychology degree. I have presented this topic at the last two New Zealand Psychological Society conferences held in Queenstown and Wellington. The following is a description of the research process from the student researcher perspective. Assistance with this project has been received from my supervisors Professor Fred Seymour, Dr Suzanne Barker-Collo, Dr Kerry Gibson, and co-researcher Fiona Howard.

I began, as most do, by reviewing the literature on the psychology profession. Existing studies were identified which focused on the many types of stressors within the mental health and health professions and the negative outcomes related to this stress (i.e., compassion fatigue, distress, and professional impairment). I was struck by just how demanding and potentially distressing the work of the psychologist is and was confronted by the long list of stressors that psychologists face. For example, stressful client behaviours, administrative demands, budgeting considerations, ethical concerns, threat of complaints.

While the research on the negative

outcomes of this stress for psychologists was extensive only a few research papers, books and articles were located that identified the possible factors that protect psychologists from these stressors. Of these, most were discussions or recommendations, not empirical studies. Because of this limitation I turned towards the broader research of positive psychology, a science that shifts the focus away from the distressing outcomes of stress and trauma towards outcomes such as strength and growth. The construct 'resilience' was identified as something that might not only protect psychologists from the stressors they face but also enable positive outcomes to be experienced during and following stressful experiences.

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By and large to be considered resilient a person must have faced a situation that poses a subjectively significant threat, adapted positively to the situation, and have continued to function within, or above (sometimes referred to as flourishing or thriving) their normal range of well-being. Well-being is a similar construct to resilience in that many of the factors that

identify someone as well (e.g., positive relationships, positive emotions, meaning and purpose, achievement and involvement) are also factors that enable someone to engage in a resilient manner when faced with stress or trauma. Resilience is also sometimes linked with recovery. Recovery suggests a disruption in well-being and the experience of negative symptoms, such as depression. A gradual return to previous, or enhanced (sometimes called growth), levels of well-being is then experienced. Resilient people, however, may experience fluctuations in their well-being but will generally maintain healthy functioning across time and stressful events.

The concept of resilience originally surfaced from research on children who had been exposed to severe adverse conditions and thrived. A large number of resilient characteristics have been identified by this early research on children and more recently by research on adults. Characteristics include self-efficacy, intelligence, having patience, tolerance of negative affect, optimism and faith (Connor & Davidson, 2003). However, by listing the characteristics of resilience, resilience became viewed as a relatively rare and trait-like. Resilience is, however, coming to be seen as common. This is in part to do with the shift towards viewing resilience as a process rather than a trait. This shift recognised resilience as a malleable quality that is constantly influenced by past and present exposure to stressful environments. Research supports this 'resilience as a process' view. For example, individuals who have experienced past environments where stress is limited and have had opportunities to recover have been found to cope better with subsequent stressors compared to individuals who have had no previous stress exposure or have had chronic stress

without recovery opportunities (Seery, Holman, & Silver, 2010). However, despite this shift the process view of resilience is still largely thought of as an individual coping process that arises from internal strengths and characteristics, resulting in external influences such as cultures, relationships and current social influences being largely overlooked or ignored.

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The notion of relational-resilience shifts the focus from an individualistic view of resilience towards a shared concept of resilience (Hartling, 2008; Jordan, 2004). Relational-resilience proposes that understanding resilience involves the consideration of social, cultural, and interpersonal factors that may enhance or obstruct one's ability to engage resiliently. At the center of the theory are 'growth-fostering' or 'resilient-enhancing' relationships (Hartling, 2008; Miller, 1986). These relationships benefit all involved and create zest or vitality, clarity about oneself, the other and the relationship, personal worth, creativity and productivity, and the desire for more connection. Essential features of these relationships are mutual empowerment and empathy within the relationship and the ability to reconnect following disruption to the relationship (Jordan, 2004). This relational reframing of resilience shifts the focus from a view that to be resilient you need the 'right stuff' towards a notion that resilience is a shared experience that can lead to resilient individuals, families, and communities. It is suggested that taking a relational perspective of resilience might result in resilience being defined as the ability to connect,

reconnect, and resist disconnection in response to adversity (Hartling, 2008). Recent conclusions in the positive psychology literature support this definition by stating that "resilience rests, fundamentally, on relationships" (Luthar, 2006, p. 780).

The results of the literature review led to the development of a model of resilience in psychologists (currently being written up for publication). The model included a relational-cultural component (i.e., past environments, professional cultures and growth fostering relationships), a process component (i.e., resilient characteristics, the experience of positive emotions and coping/self-care during stress), and an outcome component (i.e., growth, compassion satisfaction and quality client care). Each component illustrated different aspects involved in the development and maintenance of resilience within the psychologist and their colleagues.

Quantitative and qualitative methods were chosen to test the different aspects of the model and in 2011 a survey of resilience in New Zealand psychologists was sent out through the New Zealand Psychological Society and the New Zealand College of Clinical Psychologists. There was a great response to the survey with over 300 starting and 224 completing. Path analysis, a theory testing technique, was used to test the process component of the model. Interestingly the survey results supported a relational/environmental view of resilience. Also of interest was that the two outcomes measured, growth and professional quality of life (high compassion satisfaction, low fatigue), were not related when placed into the model. I have interpreted this to suggest that these two outcomes may be independent of each other, or related in ways that were not captured by this particular model. This is

important as it is theorised that the ability to experience growth is what helps maintain the resilient process and goes against some of the current definitions of resilience that include not only maintained well-being (i.e., have low burnout and secondary traumatic stress) but also the ability to grow, flourish or thrive following adversity.

the psychology profession is likely to lead to the development of workshops, interventions and training programmes that support the development and maintenance of resilience in psychologists. Understanding resilience better may also provide a framework for supervision relationships and the specific professional aspects of resilience

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In 2012 two focus groups were conducted to explore the experiential and relational aspects of the model. The two groups consisted firstly of psychologists with less than ten years' experience (N=5), and secondly of psychologists with more than ten years' experience (N=8). Preliminary analysis of the focus group data has supported the model components and, in particular, the importance of the relational component of resilience (e.g., through teams that create a "culture of care", relationships outside of work, personal therapeutic relationships, and relationships with supervisors) and the impact that the mental health culture has on one's resilience. Furthermore, general consensus from the groups was that the discussions were enjoyable, normalising of experiences and difficulties and concluded that further resilient discussion groups would be beneficial. A number of tensions were also discussed including an underlying tension between appearing resilient, versus valuing vulnerability and the importance of, versus the restrictions of, supervision and the supervision relationship.

The implications of this work are yet to be fully explored. However, having a greater understanding of resilience in

(e.g., therapy beliefs and coping with secondary trauma). Furthermore, the results from the survey and the preliminary results of the focus groups confirm that resilience is not something that is located within an individual rather something that is shared and accessed through one's relationships, professional cultures and environments. Therefore, I believe that it is up to us (those, like myself, who are about to enter the profession right up to the most experienced) as a group, to support and nurture resilience with this profession (suggestions on how to do this are welcome!).

This work has impacted on me in a number of ways. I am, of course, still a student, yet I feel I know a lot more about my future profession than I would do if I was studying a different topic. I value greatly the generous sharing my participants have had in giving me this knowledge. Yet, despite my own experiences of burnout (in my previous profession as an illustrator) I feel out of my depth when presenting this information when I have not personally experienced what has been discussed. I am also left with a feeling of responsibility for a profession I have not yet entered. In a way I feel like a

"parentified" student who has had to grow up too soon. On a more positive note, I no longer see my training as something that will provide me all the answers and skills to be an effective and competent psychologist. Instead I recognise that there is much more for me to learn once I get out there; including the privilege of hearing, being with, and working with clients who despite experiencing great difficulties have shown both the ability to recover and be resilient. This, I am looking forward to.

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Qualitative Assessment of the Cognitive Outcomes of Electroconvulsive Therapy

Luther, K.M., Leathem, J. M., & Humphries, S. A. (2012)



Kiri Luther recently completed her Doctor of Clinical Psychology at Massey University, Wellington. She is currently a registered clinical psychologist in the Adult & Family Team at WellStop. Her areas of interests include forensic and criminal psychology, and neuropsychology. Her thesis research investigated both objective and subjective assessment of cognition in adults who had received electroconvulsive therapy (ECT) in Wellington more than two years prior to the research. This was both a challenging and rewarding area to study. Kiri has presented her research at various conferences including the Annual ECT Conference and the joint NZPsS and NZCCP conference where she was the winner of the NZPsS Best Student Conference Paper.

Introduction

It is now widely accepted that electroconvulsive therapy (ECT) has side-effects in the form of cognitive impairment, however there is still much debate as to the actual nature and duration of these deficits and how best to assess them (National Institute for Clinical Excellence (NICE), 2003).

NICE (2003) considered a number of studies and patient testimonies which suggested that the objective measures used in random controlled trials (RCTs) were not adequately measuring the nature of the cognitive difficulties associated with ECT. A number of qualitative studies were cited suggesting longer term and permanent cognitive difficulties. They therefore suggested that research was required into the long term cognitive difficulties associated with ECT with an emphasis on both objective and subjective assessment.

Few studies into the cognitive outcomes of ECT have attempted to utilise qualitative assessment as a way of investigating subjective experiences and many of these have utilised objective measures such as the Squire Subjective Memory Questionnaire or the Cognitive Failures Questionnaire (Koopowitz, Chur-Hansen, Reid, & Blashki, 2003; Berman, Prudic, Brakemeier, Olfson, & Sakeim, (2008); Brakemeier, Berman, Prudic, Zwillenberg & Sackeim, 2011).

The current research utilised interpretative phenomenological analysis (IPA) to assess individuals' subjective experiences. There are no set rules for how IPA is conducted; rather an overall framework is suggested

(Smith & Osborn, 2008). While many IPA researchers tape record the discussions, a number also use narratives, and occasionally researchers utilise a semi-structured format which guides the process (Smith & Osborn, 2008).

It is now widely accepted that electroconvulsive therapy (ECT) has side-effects in the form of cognitive impairment....

The aim of this research was to allow past ECT patients to openly discuss their experiences of ECT, memory and cognition in both the short term (during and after ECT) and in the long term (currently). By doing so the research would add to the limited qualitative research into the cognitive outcomes of ECT. As a previous literature review revealed, IPA has not been used to assess subjective experiences in an ECT population, therefore this study would essentially be trialling a new form of assessing cognitive complaints. In keeping with the framework of IPA, no predetermined hypotheses are stated (Smith & Osborn, 2008).

Participant Recruitment and Demographics

Ethics approval for this study was given by the Central Health and Disability Ethics Committee in December of 2008. A total of 19 participants consented, (n=14 female, n=5 male). Refer to Table 1 for demographic information.

All participants had received their final ECT treatment more than two years prior to the assessment. Two years was chosen due to literature suggesting

Table 1

Participant Demographic Information

<i>N=19 (n=14 female, n=5 male)</i>	Mean (Standard Deviation)	Range
Age (years)	46.95 (12.76)	21-64
Education (years)	14.40 (2.99)	10-20
Time Since Last ECT (years)	7.7	2.3-11.8
Number of Treatments per week	1.92 (0.39)	1.25-3.00
Total Dose per person (mC)	5997.00 (10546.57)	325.00-37494.00
Total Number of ECT sessions per person	24.32 (40.43)	3.00-161.00

that after traumatic brain injury people, return to best functioning by the two year post injury point (Lezak, Howieson & Loring, 2004). It was considered that this would likely apply also to those who had received ECT.

Procedure

Participants were assessed for their motivation towards testing using Trials 1 and 2 of the Test of Memory Malinger (TOMM). Participants were then administered two tests of depression, the Beck Depression Inventory Version Two (BDI-II) and the Montgomery Asberg Depression Rating Scale (MADRS).

It was decided that recording the interviews would not be done due to privacy, but rather participants would be asked to write down their experiences under two broad headings:

“Please write in your own words any problems you have experienced from ECT”.

“Please write in your own words any benefits you have experienced from ECT”.

Analysis of Data

Personal accounts were analysed on an individual basis, with each narrative being read a number of times. The

researcher was constantly drawing themes and concepts from what each participant had written (Smith & Osborn, 2008). Once all interviews had been coded they were looked at as a group for emerging themes and concepts.

The aim of this research was to allow past ECT patients to openly discuss their experiences of ECT, memory and cognition...

Results

All participants scored at acceptable levels on the TOMM. Mean scores on the BDI-II ($M=18.12$, $SD=18.27$), and on the MADRS ($M=13.26$, $SD=12.37$) both suggested mild depressive symptomology. However, standard deviations for both tests' means were variable suggesting that some had moderate/severe depression.

Of the $N=19$ participants, $n=1$ had never experienced cognitive deficits, $n=1$ had experienced cognitive deficits in the short term (close to the time of ECT), while $n=17$ still experienced deficits and that these had begun during the ECT treatment and had not changed noticeably over time.

Brief Summary of Qualitative Analysis

1) Retrieval

Of the 89.5% who did experience difficulties with memory and/or cognition, 79% reported retrieval deficits. Of these people, 84% also reported difficulties with personal memories, 42% with visual information, 37% with retrieving auditory/verbal information, 32% with day to day memory and forgetting, 26%

with new learning and 16% (respectively) had difficulty retrieving directions procedures. Following are some of the excerpts which illustrate this:

Personal Memories

“I have no recollection of a relationship at the end of 2002 or completing a paper towards my degree”

“The feeling is similar to an extreme hangover...did I actually do that, read that, see that, or did I dream it”

“I can't order the timeline I was recently doing my CV and it was like piecing together a difficult puzzle, my husband had to help”

Procedures

“When I returned to work I could not remember important information, details, procedures...that meant I was unsafe in my practice and could not continue”

“I couldn't remember how to perform dialysis...nearly bled a person's blood into a bucket...tuned in before it was too late, phew”

“Sometimes I think, is this really happening, you've been taught this a thousand times, how to do this, but you've gone blank”

Auditory/Verbal Information

"It's hard to participate in conversations that are with more than one person, where the conversation is about facts rather than feeling, and when the conversation moves too quickly...I have to work hard to process what I'm hearing...I have a better chance of remembering points of conversation if I'm involved in them, if there is repetition of information, if I'm not hurried and if I can create an image of link to an experience"

"I can't explain things to people... following conversations are hard and if I don't butt in and say something I forget what it is I want to say, and then what the conversation is about"

Visual Information

"When trying to read information, books, words are just words and are not connected together"

"I still have problems with faces"

Day to Day Memory/Forgetting

"It's like when you walk into a room and forget what you're there for. It's like that but a lot worse and hundreds of times a day"

"It's like searching in the dark for something you don't know, and a rising panic, this happens dozens of times a day"

"I forget where I've parked the car...I am standing there visually scanning the parks, I've gotten upset many times and had to be picked up"

New Learning

"I have lost my ability to learn in any significant way. This ranges for normal day to day learning or more formalised. Makes me sad and frustrated"

"I wonder if this is what it's like to have a learning disability"

Directions

"It's hard to remember how to get to

places when I am driving the car, even on familiar routes"

"In town one day I had no idea how to get home, I had to ask directions, I was completely blank, didn't know which way to go"

"I can't remember how to get from point A to point B even though I've done it before"

2) Attention and Concentration

Of the 89.5% who reported difficulties, 32% reported deficits with attention and concentration:

Staying on Task

"I get confused at times, a continuum of confusion"

"I forget what I'm doing quite a bit"

"I get distracted easily and it takes time to get refocused"

3) Executive Functioning

Of the 89.5% who reported difficulties, 21% reported deficits with executive functioning. Specifically, 21% had difficulty with sequencing, and 21% had difficulty multi-tasking:

Sequencing

"I remember sitting in the shower a lot, not knowing what to do with myself, got very confused...the order of which

I needed to do things to achieve... something out of whack...it happens even now"

"It's like baking a cake, must do things in order to get the right result. Pieces are all there but can't seem to put in the right order so I'm not getting the right answer or outcome"

Multi-Tasking

"I'm not able to multi-task like I once could"

"I could only concentrate on doing one thing for a very long time"

A number of other themes also emerged during the interview which weren't directly related to cognition. These are presented in table 2.

Despite 89.5% of participants still experiencing cognitive deficits, 68.4% of them claimed ECT helped their mental health.

Discussion

The results of this study indicated that most participants had mild depression, and a high number reported that ECT had helped them. However even mild depression can exert influence on memory and cognition and there was variability in depression scores so these results need to be viewed with some caution.

Table 2

Other Emerging Themes

Theme	% of Participants Experiencing Theme (N=19)
Benefited Mood	68.4
Embarrassed about needing ECT	26.3
Disbelief at needing ECT	15.8
Frightened of ECT	31.6
No Memory Problems at all	10.5
Staff were kind	31.6

Secondly, three themes emerged; participants were having difficulty retrieving information, with attention and concentration, and with aspects of executive functioning.

Over half of the participants reported that ECT benefited them, despite having cognitive difficulties currently.

Other important themes arose during the interviews. Over half of the participants reported that ECT benefited them, despite having cognitive difficulties currently. The theme of fear was mentioned frequently, as was *embarrassment at needing ECT*. A number of participants commented on the kindness of the staff involved with ECT suggesting this is an important aspect of the treatment process.

Finally, many who were experiencing cognitive deficits presently had been experiencing the same deficits acutely suggesting that for this group, the deficits had not changed with time. This is important as it suggests that those who experience lasting difficulties experience the same difficulties in the short term and that deficits do not change over time. It is unclear what influence normal ageing exerted on participants difficulties. A number of participants were in the *older* age range (over 45 years), however

a number of the younger participants, as young as 21 years, were also reporting difficulties.

Future qualitative research may wish to investigate the themes of attention and concentration, and executive functioning to establish whether they might be part of the same deficits or two standalone deficits. An investigation into information processing would also be worthwhile as it may be exerting an influence on the other domains which participants reported having difficulties with.

Finally, future qualitative research may wish to include depressed groups who have not had ECT as a way of controlling for any effects of depressive symptomology.

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The Etiology of Inflated Responsibility

Kirsty Fraser



Kirsty Fraser is in the final year of completing her PhD in Psychology at Victoria University of Wellington. She studies part-time while working as a teaching assistant for an Abnormal Psychology paper, an external marker for the Open Polytechnic of NZ, and looking after her one year old son. Kirsty's research interests include anxiety, depression, thought patterns and self-harm. Kirsty hopes to continue in an academic role, with a passion for teaching and lecturing, and having won various teaching awards within psychology.

and Thought-Action Fusion in Psychopathology: Current Research

Thought-action fusion (TAF) is a phenomenon whereby an individual has difficulty separating intrusive thoughts and their corresponding behaviours (Marino, Lunt & Negy, 2008). Rachman and Shafran (1998) defined TAF as “the psychological phenomenon in which the patient appears to regard the obsessional thought and the forbidden action as being morally equivalent and/or feeling that the obsessional thought increases the probability of the feared event” (p. 72). TAF has since been dichotomised into *moral* and *likelihood* components. TAF *moral* is the notion that unacceptable cognitive intrusions about disturbing events are morally equivalent to the actual occurrence of these events (Abramowitz, Whiteside, Lynam & Kalsy, 2003). TAF *likelihood* refers to the idea that thinking about a distressing event causes that event to become more probable. TAF *likelihood* is further divided into *likelihood-self* where the individual believes their thoughts increase the probability that a distressing event will happen to themselves. For example ‘*if I think about being in a car accident, this makes it more likely to happen to me*’, and *likelihood-other* where the individual believes their thoughts will increase the probability of negative events occurring to other people, for example ‘*if I think about my best friend being in a car accident, it is more likely that they will be in an accident*’ (Abramowitz, et al., 2003).

TAF and inflated responsibility are often referred to in the context of their occurrence in obsessive compulsive disorder (OCD). OCD is a debilitating anxiety disorder characterised by intrusive, disturbing

thoughts/obsessions, and repetitive, compulsive behaviours (Chamberlain, Blackwell, Fineberg, Robbins & Sahakian, 2005). The obsessions of OCD typically involve distressing *thoughts* of contamination, socially unacceptable thoughts and behaviours, and harm or death of a loved one; they can also involve a preoccupation with counting and symmetry (Chamberlain, et al., 2005). Compulsions can include *behaviours* such as excessive hand washing, making objects symmetrical and repeated checking (e.g. light switches and door locks; Chamberlain, et al., 2005).

AF and inflated responsibility are often referred to in the context of their occurrence in obsessive compulsive disorder (OCD)

Previous studies have repeatedly demonstrated a relationship between TAF and OCD, with stronger positive correlations for *likelihood* TAF than for *moral* TAF (Amir, Freshman, Ramsey, Neary & Brigidi, 2001). TAF has been described as being a contributing factor in the maintenance and development of OCD for two main reasons. First, the belief that thoughts are the moral equivalent of their occurrence is likely to cause the individual to become distressed and upset at having these thoughts (Abramowitz, et al., 2003). Second, as a consequence of the belief that their thoughts will increase the probability of an unwanted event occurring, OCD patients may engage in certain neutralising behaviours and compulsions in order to prevent these negative events from occurring (Abramowitz, et al., 2003).

Inflated responsibility also plays a significant role in OCD (Rachman, Thordarson, Shafran & Woody, 1995). As Salkovskis and Kirk (1989) describe, obsessional thought often involves some fear of personal responsibility for preventing harm, either to the self or others. Many experimental and correlational studies support the role of responsibility beliefs in OCD (e.g. Rachman, Thordarson, Shafran & Woody, 1995; Smari & Holmsteinsson, 2001; Yorulmaz, Altin & Karanci, 2008).

Some research has suggested that TAF and inflated responsibility beliefs may not be confined to OCD. Associations have been found with a number of other disorders, including depression, eating disorders and anxiety disorders (Berle & Starcevic, 2005). The results from the first study of the current research support this. Analyses using structural equation modelling showed that inflated responsibility beliefs play an integral role in symptoms of depression, anxiety and obsessive compulsive disorder amongst 193 undergraduate students. Correlational results showed responsibility beliefs to be related to anxiety and depression while controlling for obsessive compulsive symptoms, suggesting these types of beliefs are a more general cognitive bias, as opposed to a specific symptom of OCD.

Because TAF appraisals and inflated responsibility beliefs have been found to play a part in the development and maintenance of a range of disorders, it is important to assess whether they are susceptible and amenable to change through therapy. Early promising research on this by Rassin, Diepstraten, Merckelbach and

Muris (2001) found that TAF beliefs decreased after successful cognitive-behavioural treatment of OCD and other anxiety disorders, although it was not specifically addressed. This suggests that perhaps the potency of therapy would be enhanced if there was some specific focus on TAF and responsibility beliefs. In a study with 72 undergraduate students, Zucker, Craske, Barrios and Holguin (2002) found that providing participants who scored highly on measures of TAF with educational 'anti-TAF' scripts normalising intrusive thoughts, reduced anxiety and the urge to neutralise. Unfortunately with this research there were no follow-up assessments, so it is unclear whether these promising effects were persistent over time.

As Beck (1976) describes, experiences occurring during childhood and adolescence are crucial to forming potentially dysfunctional attitudes later in life.

There have also been encouraging findings in terms of correcting inflated responsibility beliefs through therapy. For example, Ladouceur, Leger, Rheume and Dube (1996) evaluated the efficacy of cognitive therapy targeting only inflated responsibility in four patients with OCD, using four key strategies: (a) targeting inflated responsibility (identifying situations in the patient's own life); (b) awareness of automatic thoughts; (c) correction of negative automatic thoughts; and (d) development of adequate perceptions of personal responsibility. All subjects reported a significant decrease in OC symptoms, as well as a decrease in perceived responsibility. These effects were maintained at follow ups (6 and 12 months) for three of the patients. In a more recent study, cognitive behavioural group therapy targeting inflated responsibility was found to

significantly improve responsibility beliefs in 28 patients with OCD (Haraguchi, Shimizu, Ogura, Fukami, Fujisaki & Iyo, 2011). Interestingly, results showed that while the treatment improved responsibility attitudes, the frequency of negative intrusive thoughts did not change.

Given the growing body of evidence supporting the important role of responsibility beliefs in the development of psychopathology, it makes sense to investigate their origins and factors which lead to their development, which is the direction of the current research. As Beck (1976) describes, experiences occurring during childhood and adolescence are crucial to forming potentially dysfunctional attitudes later in life. In an attempt to explain the possible origins of inflated responsibility, Salkovskis, Shafran, Rachman and Freeston (1999) proposed a model of five interacting pathways. These factors are hypothesised to be involved in the development of inflated responsibility:

1. An early developed and broad sense of responsibility that is deliberately or implicitly encouraged or promoted during childhood.
2. Rigid and extreme codes of conduct and duty.
3. Childhood experiences where sensitivity to ideas of responsibility develops as a result of never being confronted by it.
4. An incident in which one's actions or inaction actually contributed in a significant way to a serious misfortune which affects oneself or others.
5. An incident in which it appeared that one's thoughts and/or actions or inaction contributed to a serious misfortune.

Until recently, this theory of multiple pathways remained untested. Coles

and Schofield (2008) developed a 23 item, self-report measure to directly

T- Understanding the etiology of inflated responsibility may lead to important clinical implications. Interventions can be targeted at preventing or modifying the development of inflated responsibility beliefs.

assess this theory; the Pathways to Inflated Responsibility Beliefs Scale (PIRBS). As well as developing the measure, Coles and Schofield also had participants complete a measure of OCD symptoms. The results showed a significant correlation between the frequency of OCD symptoms with overall PIRBS score, as well as with all individual subscales. This finding provides support for linking the childhood experiences described by Salkovskis et al. (1999) with OC symptoms in later life.

Salkovskis et al.'s (1999) theory of multiple pathways to inflated responsibility describes a list of childhood experiences that can lead to an individual developing a vulnerability towards inflated responsibility, and OC symptoms. While initial research by Coles and Schofield (2008) has shown promising results in support of this theory, it is important to note that these external experiences are likely to interact with internal, cognitive factors (e.g. locus of control). Whilst many individuals may experience one or more scenarios described in Salkovskis et al.'s model, only a few may go on to develop inflated responsibility of a clinical level. How one interprets and thinks about their experiences must also play an important role.

The second study of the current research focused on the etiology of both inflated responsibility and

thought-action fusion. The aim was to investigate both the external and internal contributors to developing an inflated sense of responsibility. For external factors, Salkovskis et al.'s (1999) model of multiple pathways was tested using the PIRBS (Coles & Schofield, 2008). It was predicted that those individuals who showed high scores on the PIRBS would demonstrate a higher level of inflated responsibility. For internal, cognitive influences, participants also completed a measure of locus of control. Results using hierarchical multiple regression revealed that high scores on the PIRBS, and an external locus of control were both significant predictors of inflated responsibility. Additionally, the interaction between the PIRBS scores and external locus of control predicted inflated responsibility over and above the individual variables. This study is currently being replicated with a clinical population.

An additional consideration for the current research is the link between

may go on to become involved in religion. Additionally, it is likely that the relationship between religiosity and responsibility involves a complex interaction between factors including individual characteristics (of the person and the religious teachings), and childhood experiences (Abramowitz et al., 2004; Salkovskis et al., 1999).

The fact that TAF has been found to play a part in the development and maintenance of a number of psychological disorders, and that TAF has repeatedly been found to correlate with religiosity, may lead one to assume that religious people are therefore at higher risk of pathology. However, this is not the case. Interesting research by Siev, Chambless and Huppert (2010) evaluated TAF *moral* alongside religious affiliation and OCD symptoms. Results showed that among Christians, TAF *moral* was related to religiosity, but not OCD symptoms. The authors conclude that when TAF beliefs are culturally normative, as in religious teachings,

responsibility may lead to important clinical implications. Interventions can be targeted at preventing or modifying the development of inflated responsibility beliefs. For example, Coles and Schofield (2008) suggest implementing early prevention programs designed specifically for children in environments characterised by the five pathways of Salkovskis et al. (1999).

Although they are distinct constructs, TAF and inflated responsibility share similar distortions in cognition which have been associated with a range of psychological disorders. Understanding the role that these beliefs play in psychopathology and where these types of beliefs come from will lead to more specific, targeted and effective psychological interventions. Research has shown promising results of inflated responsibility beliefs, TAF appraisals and thought suppression in their susceptibility to change through therapy. Therefore, the more we know about these, more successful and tailored treatment methods can be developed.

Research has shown promising results of inflated responsibility beliefs, TAF appraisals and thought suppression in their susceptibility to change through therapy.

responsibility beliefs and religiosity, particularly TAF. Religiosity has been repeatedly linked with TAF, with there typically being a stronger relationship between religiosity and TAF *moral*, rather than with TAF *likelihood* (Rassin & Koster, 2003). That is not to say that all those who have religious beliefs will also develop thought-action fusion. As Abramowitz, Deacon, Woods and Tolin (2004) suggest, those with pre-existing cognitive biases like inflated responsibility may affiliate stronger with their religious beliefs and teachings. Individuals who already score highly on TAF

they do not necessarily signal pathology, and can be an example of healthy religious beliefs. One future direction of the current research is to replicate this research by Siev et al. (2010), including a measure of depression alongside OC symptoms, as TAF *Moral* has been repeatedly linked with depression (Abramowitz et al., 2003; Shafran et al., 1996). This has important implications for clinicians and researchers in considering the context of TAF beliefs, before assuming that they represent a risk factor for psychological disorder.

Understanding the etiology of inflated

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Understanding the Supervision to Glen Kilgour

Glen Kilgour is Principal Advisor Special Treatment Unit Development at the Department of Corrections and is based in Hamilton.

The Health Practitioners Competency Assurance Act (2003) requires the New Zealand Psychologists Board to authorise the registration of psychologists under the Act, and to maintain a register. The Act also requires the Board to prescribe the qualifications required for each scope of practice within the profession and for that purpose, to accredit and monitor educational institutions and courses of studies as specified in Section 118(a)-(b) of the HPCA Act 2003. The Board's requirements for accreditation are comprehensively set out in their June 2009 publication "Standards and Procedures for the Accreditation of Qualifications Leading to Registration as a Psychologist in New Zealand".

In late 2008 the Department of Corrections, via Psychological Services, purchased the right to use the defunct New Zealand Psychological Society (NZPS) framework for a supervision to registration (StR) programme. The NZPS framework was significantly adapted by an expert panel to update the programme and to tailor it to meet the needs of the Department of Corrections and the new Accreditation Guidelines.

The Department's StR programme design was submitted to the New Zealand Psychologist's Board (NZPB) in early 2009 and the Board granted provisional registration shortly thereafter. Full accreditation was deferred to allow the programme to progress through the initial implementation phase; and the Department applied for and obtained full accreditation in early 2012.

The Department's StR programme is reserved only for trainees who meet certain criteria. They must have already been awarded a second class honours (division one) or better Masters degree in psychology. They also must have taken pre-requisite courses or be able to reasonably complete the necessary

Registration Programme: A Student Pathway

courses during their time in the programme. The required courses are psychological assessment, abnormal psychology and professional practice and ethics.

At present the programme is limited to staff working as programme facilitators in the Department's Special Treatment Units (STUs). These staff contract via a formalised written agreement to undertake additional tasks required of them during the course of their study. The contract specifies that the Department will provide negotiated study and exam leave and will pay for registration fees and texts and materials. Each trainee is bonded to continue working for the Department for two years after completion of their programme. Attainment of a position as a psychologist is subject to the Department's standard recruitment process. The employee will continue working in their substantive role until they are appointed to a psychologist position.

The StR programme is an intensive course of study over a period of approximately 18 months. Trainees are required to submit an extensive learning journal, client logs, six case studies (estimated in total to be equivalent to the work required to complete a Master's thesis) and undertake 1500 hours of supervised clinical practice. Trainees sit mid-programme examinations and final examinations. Final examinations consist of a written test and oral examinations of: case studies; file paper cases; the recording of an assessment; the report generated by the assessment and a review of learning journals and client logs.

A Supervision to Review Panel and StR Programme Director provides governance of the programme with the programme director managing the day-to-day implementation requirements.

The programme has been operating well for over three years. Four trainees have now successfully completed the programme and there are two current trainees

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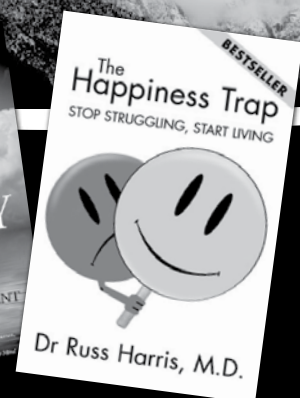
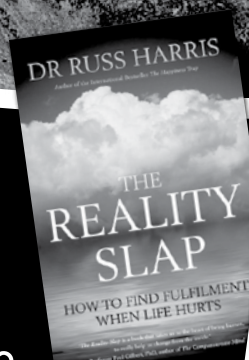


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